Mental Health Services Act
Prevention & Early Intervention

COMMUNITY REPORT EXECUTIVE SUMMARY COVERSHEET

Instructions:

1. Please use this form as a cover to any report you want to submit for review by the PEI Planning Panels.
2. Email this completed form and an electronic version of your report (Word document or PDF) to mhsa@acbhcs.org no later than December 14, 2007.

Organization: (if applicable) Afghan Coalition (On behalf of the Afghan Mental Health Council)
Contact Person: Ms. Rona Popal
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Phone No. / Email address: 510-745-1682_ afghancoal@aol.com

**Please attach a list of all groups and organizations that contributed to this report.*

What age group does your organization serve or represent?

X Children & Youth (0-18) X Transition Age Youth (14-25) X Adults (18-59) X Older Adults (60+)

Under each category, choose the item your report PRIMARILY addresses:

Key Community Mental Health Needs

X Disparities in Access to Mental Health Services
X Psycho-Social Impact of Trauma
❒ At-Risk Children, Youth and Young Adult Populations
X Stigma and Discrimination
❒ Suicide Risk

Priority Populations

X Underserved Cultural Populations
❒ Individuals Experiencing Onset of Serious Psychiatric Illness
X Children/Youth in Stressed Families
X Trauma-Exposed
❒ Children/Youth at Risk for School Failure
❒ Children and Youth at Risk of Juvenile Justice Involvement

For more detailed explanations of the terms above, please review the PEI Program & Expenditure Guidelines available at http://www.dmh.ca.gov/Prop_63/MHSA/Prevention_and_Early_Intervention/default.asp

COMMUNITY REPORT EXECUTIVE SUMMARY

Afghan Coalition, 39155 Liberty Street, Suite D-460, Fremont, California 94538

SECTION I - ORGANIZATIONAL BACKGROUND: Provide a brief history of your organization and a description of who your organization serves or represents. The Afghan Coalition and the organization's listed below recently came together to form the "Afghan Mental Health Council" that will oversee all activities in the Afghan American Community Southern Alameda County related to Mental Health issues.

- Afghan Care
- Afghan Men's group
- Afghan Cultural Society
- Afghan Women's Association International
- Afghan Jerga
- Afghan Refugee Support Center
- Lemar TV
- Society of Afghan Professionals

All these organizations are working collaboratively to develop successful Prevention and Early Intervention strategies to serve the Afghan Community. Several of these organizations, (The Afghan Coalition, Lemar Television, Afghan Cultural Society, Afghan Women's Association International and the Society of Afghan Professionals) have a history of working together and are all co-located at the Fremont Family Resource Center. Other organizations listed here comprise new partnerships in an effort to be inclusive, draw upon mental health expertise, and expand the outreach to the Afghan community. Additional appropriate groups are actively being invited to join this initiative, including representatives of the three Afghan Mosques serving this area. The Afghan Coalition, formed in 1996, is a 501(c) (3) nonprofit community-based umbrella organization whose mission is to empower underserved Afghan families, women, and youth living in Southern Alameda County by providing health and social services, advocacy, building community, developing youth leadership, and promoting cross-cultural unity. The Coalition currently oversees the Afghan Health Partnership project, designed to work with local medical providers to improve their cultural competency in serving the Afghan population and in advocating for better access to health services for Afghan residents. The project is funded through a grant from the California Endowment.

Although population estimates vary, local community groups and city officials estimate that there are approximately 10,000 - 15,000 Afghans in Southern Alameda County, with the largest number of Afghan families living in the city of Fremont (but see Data Sources below). The Afghan community consists of people, primarily refugees and asylees, from both rural and urban areas of Afghanistan with very different educational and socio-economic backgrounds as well as their second generation children. The community includes Pashtu and Dari speakers. The majority of the Afghan Coalition's clients are living in the East Bay cities of Fremont, Hayward, Union City, and Newark. Of clients served by the Afghan Coalition, 90% are Afghan. The other 10% are Pakistani, Indian, Arab and Iranian. To reach the underserved Afghan community, outreach takes place through word-of-mouth and through the many workshops and community events organized by the Coalition. The Coalition also utilizes local cable television, through its partner organization Lemar Television, to educate and increase community awareness on a variety of issues. Many older Afghans have limited English speaking ability, and a number of the elderly Afghan women, in particular, remain illiterate in their own language, so television provides a vital communication link. The Coalition and many of its co-located Afghan partner organizations share space at the Fremont Family Resource Center (FRC), which gives them all easy access to the wrap-around services by other providers also housed at the FRC such as County and City Mental Health providers, County Social Services Public Health, EDD, Safe Alternatives to Violent Environments (SAVE) and many others located in this center.

SECTION II - DATA SOURCES: Provide a description of where and how you obtained data and information to support your findings and recommendations, e.g. census data, local survey and focus group data, published research data, etc.

It is difficult to obtain accurate information about the health and mental health needs of the Afghan population. Based on the size of membership lists of mosques serving Afghans in Hayward and Fremont, and estimates of non-membership rates of younger generation adult Afghans, the 2000 U.S. Census greatly undercounts Afghans in Alameda County. Unless self-designated, Afghans have been counted as "Caucasian" in the census data. Data has been gathered by local researchers and through client questionnaires developed by Afghan serving organizations. A comprehensive health and mental health survey by California State University, East Bay, Professor Carl Stempel is presently in process. It will provide measures of rates of depression, posttraumatic stress, anxiety disorders, paranoid ideation, and obsessive, and hostility and link these to factors like previous traumas, social isolation, family structure and practices, date of arrival, occupational status, and intergenerational conflict. The present study will include much needed data on Afghans who have arrived in the U.S. and the East Bay since 1990. Data from this study will be available in early 2008.

In 2001, a pilot study of 65 adult Afghans was completed by Dr. Zamani and Professors Dale and Stempel. Almost all of these Afghans arrived in the U.S prior to 1990. (Dr. Zamani is director of Afghan Care, a non-profit which is part of the Mental Health Council.) Findings reported by Stempel and Zamani state, "Any efforts to assist adult Afghans" as they adjust "may not work unless serious psychological problems are addressed. Many Afghans have been traumatized by war that they left behind, and many have experienced culture shocks of various types. Although the extent and effects of trauma are hard to measure through surveys of clients, we found high levels of several symptoms that are related to either post-traumatic tress or expression." The Afghan Care survey found that 42 % of the respondents had recently been having bad dreams and nightmares, and 35.9 % were having difficulty sleeping. Many of these were experiencing a variety of other psychological problems such as hypervigilence, flashbacks to traumatic experiences, feelings of anxiety and danger, and loss of interest in life activities.

The Afghan Care Survey found that the experience of symptoms of post-traumatic stress disorder (PTSD) and depression is much higher among older Afghans; of those surveyed, 87.5% had two or more symptoms of PTSD. Women and men both suffer from these symptoms, but it may be that men face greater difficulties related to loss of occupational status and what they describe as "a loss of control over their children." The younger generation of Afghans report that their fathers are or were often depressed and agitated about their dim prospects for suitable work in this country. When treating, especially elderly Afghans, for psychological problems it is important that Afghan healing methods are recognized and integrated into the treatments. In the Afghan Care Survey 44.7 % respondents reported that they use traditional medicine for treating illnesses.

SECTION III - RECOMMENDATIONS: Provide a summary of your organization's findings and/or recommendations with respect to your understanding of the purpose and goals of prevention and early intervention programs as described in the **DMH Prevention & Early Intervention Program & Expenditure Guidelines*. Include any recommendations regarding priorities and strategies. Please cite best practices where applicable. Refer to DMH Guidelines for information on ***mental health needs***, ***priority populations***, and ***outcomes*.**

The Need:

Dr. Khalil Rahmany, an Afghan clinical psychologist with fifteen years of experience serving this Afghan community recently stated that the unmet need for mental health services is so great that present services are a "drop in the bucket." Dr. Roya Sakhai, Director of the Multi-Lingual Counseling Center in Oakland, which also serves many Afghan clients, strongly agrees that the need is far greater than available services. Rahmany says that Afghan organizations do good work, but they are under funded, so outreach is limited to a small part of the population. Even with the limited help available, often people who need help don't know that the limited help exists.

Three primary trends have emerged from studies of the Afghan Diaspora which suggest that the Afghan community in Southern Alameda County represents a priority at-risk population for mental health needs. First, nearly all of the first generation adults, older adults, children, and youth are survivors of trauma. Since 1979 to the present, millions of Afghans have been forced to flee from their home country to save their lives. The Afghan exodus has at times accounted for up to "one-half of the world's estimated refugee population" (Zulfacar, 1998, p. 59). Afghan refugees fled Afghanistan from the 1980s into the new millennium following the Soviet invasion, the Mujahedeen takeover, the

Taliban rule, and the U.S. led military action against Afghanistan's Taliban regime. The years of warfare have not ended with the election of President Hamid Karzai in 2004, as violent outbreaks by the Taliban continue and are increasing. The refugee exodus began when the Soviets invaded Afghanistan in 1979. In 1992 the internal Mujahedeen forces took control over the government and civil war increased. By 1998 the Taliban had seized power of over 90% of the country (*History of Afghanistan*, 2005). As the largest single group of refugees in the world, by the new millennium Afghan refugees faced an "increasing lack of hospitality" and in some instances "downright hostility" not just from neighboring countries but "across the world" (Colville, 2001). In July of 2001 the United Nations High Commissioners for Refugees (UNHCR) released briefing notes expressing its concern over the dramatic increase in Afghan asylum-seekers during the previous four years as conditions in Afghanistan deteriorated. The notes state, "Overall, the picture concerning Afghans – the single biggest group of refugees in the world at four million or more – is about as grim as it can get" (Colville, 2001). Not only have Afghans represented the largest refugee population for years, but they are also distinct from other refugee groups in that their country has experienced multiple civil wars and invasions for decades because of its politically strategic geographical location, among other reasons.

Refugees in acute crisis situations leave their homelands suddenly, with little prior planning, and with no choice about their destination (Kunz, 1981). As Dr. Khalil Rahmany, an Afghan clinical psychologist with fifteen years of experience serving this Afghan community states, "They did not even have the chance to bring valuable items with them, because it was a run for their lives." Enduring memories of severe trauma experienced in their countries of birth accompanied by the stress of often treacherous journeys of forced migration and confusing demands of unexpectedly adjusting to a new way of life in a strange land distinguish the mental health needs of refugees from voluntary migrants. Voluntary immigrants feel pulled to a land of new opportunities and have time to contemplate and prepare for that new life, whereas refugees are pushed from a land of danger (Stein, 1981, p. 322). Dr. Rahmany states that 90% of the clients he sees have multiple psychological issues because of these traumatic experiences. In his expert opinion, PTSD is the primary mental health issue in the Afghan community. As far as the clinical population he sees, "People have been threatened with death and have witnessed family members being killed."

Second, the first generation adults, older adults, children, and youth consist of an ethnically and racially diverse population facing many challenging adjustment factors to living in the United States. As an example, Dr. Farid Younos, an Afghan professor educated in sociology, anthropology and human development, states one effect of the difficulties of adjusting to a new country, "When these conservative, tribal Afghan people arrive in the United States, the liberal and diverse atmosphere here is very difficult to accept, often leading to quarrels with one's spouse and children." In addition to increased tension in the family, as another example, Afghans may experience stress from their lack of familiarity and comfort with the idea of service organizations to assist them with short-term and long-term resettlement and adjustment issues. Refugees may be "reluctant to use resettlement facilities and services and may find it difficult to discuss their personal problems, particularly through an interpreter" (330). Edwards (1986) learned that Afghan refugees hold reciprocity and independence as two key values of their culture. They culturally resisted the idea of receiving regular help from relief agencies because they would "betray their own notions of the reciprocal nature of exchange relations," thereby placing "themselves in a dependent position" (318). The U.S. service agencies may have little "understanding of the new refugees' beliefs and practices," thus further complicating access (330). These are just two examples of the many challenging adjustment factors that arise which cause mental pressure for Afghan refugees and their families. Because the Afghan community is concentrated in Southern Alameda County, it offers a unique opportunity to address mental health needs in a culturally appropriate manner, taking into consideration cultural beliefs and practices.

Third, many of the second-generation children of Afghan refugees and asylees are struggling with an identity crisis as they try to live in an Afghan culture in their home and in a U.S.-based system at school and work, while the elderly who do not go to school or work experience isolation. Dr. Rahmany indicates, "Perceptions are formed in early childhood about what life is like universally. How parents and grandparents perceive the world when they were raised in Afghanistan is entirely different from how children and young people perceive the world that are raised here. This creates profound distress in the family dynamics. Parents have expectations, formed from their backgrounds, for their children that the children here may not even understand that the parents expect. No real communication or understanding occurs, directly impacting the well being of the family. The reason that grandparents and the elderly resist acculturation is because it devalues their past and is a betrayal for them causing heavy guilt and severe

depression. They protect themselves from the severe depression by hanging on to old values." The resulting schism, or generation gap, created in families' causes' tremendous mental and emotional distress for all involved.

Recommendations:

Based on the information and data provided above, the Afghan Mental Health Council strongly recommends the use of Prevention and Intervention Mental Health resources to assist the highly underserved Afghan population. The strategies we propose are to provide ethnically and culturally specific programs and interventions to meet the unaddressed emotional and behavioral problems of this target population as follows:

- Enhance the work already being done by Afghan organizations which are recognized as culturally appropriate services providers by the Afghan Community, as well as create new services
- Provide resources for services in the following three categories: 1)youth 0- 26 years of age, 2) families with children: 3) elderly Afghans, especially men (current services exist for Elderly Afghan Women through the Afghan Elderly Association and service referrals will be coordinated with them)
- Establish a network of mental health providers and mental health support groups that serve Afghans. Afghan-serving mental health professionals, working with Afghan-serving organizations, will take the lead on this. This will entail networking existing and newly implemented programs, raising awareness of the range of providers within the network, and establishing pathways to the network for diverse groups of Afghans.

SPECIFIC SERVICE STRATEGIES:

1) **Youth Project:** Through workshops and support groups, target resources to at-risk Afghan youth to bring hope and optimism to those youth struggling with issues of cultural identity, depression, stress and loss of self-esteem; teach strategies to increase resiliency and problem solving techniques, so young people can be successful and develop leadership skills. Reaching youth will entail partnering/networking with contact points such as school counselors, medical doctors, mosques, afterschool programs, police departments, etc. Develop inter-generational opportunities so older professional Afghans can serve as youth mentors and role models. Provide Parent education on "bridging cultural gaps and parenting techniques" and offer referrals for youth with serious mental health problems to culturally appropriate clinical services.
2) **Family Support:** Through workshops, support groups and cable television, offer educational programs to increase Afghan awareness about mental health issues, especially to those exposed to traumatic events and conditions, and to reduce the stigma of seeking assistance for mental health problems. Use these approaches to promote learning and self-help. Integrate this educational and support process with comprehensive case management services so Afghan families can receive services in a culturally appropriate and holistic manner.
4) **Afghan Care for Elderly Men**: Enhance the work of Afghan Care, which currently serves 100 Afghan elderly men, by providing a psycho-social support group and mental health education, to reduce isolation and depression and promote a positive mental outlook. When Afghans socialize with others, this socialization has a large influence on their well being. They feel very connected; it's a bonding issue at the basic human level: "How are you? How is your family doing?" This connection and bonding has a therapeutic effect. Many of these elders have been exposed to traumatic events and prolonged traumatic conditions, including grief, loss and isolation, and they are the most unlikely to seek help from any traditional mental health service. Help can be provided to re-integrate these elders, many of whom feel they have lost status in the Afghan community, by engaging their wisdom and expertise to support Afghan youth and their community. Efforts will be made to help coordinate services for these Afghan men to enhance their civic engagement, to improve mental health.

Implementation of these strategies will involve the close collaboration and oversight of multiple Afghan organizations, working together, to help its community achieve positive mental health outcomes, to reduce stigma associated with mental health problems and to increase access to both culturally acceptable mental health support services and, as needed, to more traditional clinical mental health services

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Acknowledgements:

Suzanne Shenfil (Director of Human Services in City of Fremont)

Valerie Smith (Instructor from Department of Communication at Cal State of east Bay)

Mental Health Services Act
Prevention & Early Intervention

COMMUNITY REPORT EXECUTIVE SUMMARY COVERSHEET

Organization*:	Asian Pacific Psychological Services & Asian Community Mental Health Services
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Phone No./ Email address:	510-835-2777 x13, blee@appsweb.org

**Please attach a list of all groups and organizations that contributed to this report.*

What age group does your organization serve or represent?

X Children & Youth (0-18) X Transition Age Youth (14-25) X Adults (18-59) X Older Adults (60+)

Under each category, choose the item your report PRIMARILY addresses:

Key Community Mental Health Needs

- X Disparities in Access to Mental Health Services
- ❒ Psycho-Social Impact of Trauma
- X At-Risk Children, Youth and Young Adult Populations
- ❒ Stigma and Discrimination
- ❒ Suicide Risk

Priority Populations

- X Underserved Cultural Populations
- ❒ Individuals Experiencing Onset of Serious Psychiatric Illness
- X Children/Youth in Stressed Families
- ❒ Trauma-Exposed
- ❒ Children/Youth at Risk for School Failure
- ❒ Children and Youth at Risk of Juvenile Justice Involvement

Prevention and Early Intervention - Community Report Executive Summary
Asian Pacific Psychological Services & Asian Community Mental Health Services

SECTION I - ORGANIZATIONAL BACKGROUND:
Asian Community Mental Health Services (ACMHS) and Asian Pacific Psychological Services (APPS), are community-based mental health agencies are working in partnership with mainstream and community providers to meet the needs of Asian and Pacific Islander Communities in Alameda County.. ACMHS was established in 1974 by community providers, activists, and progressive citizens concerned about the well-being of low-income Asian & Pacific Islander (A&PI) immigrants and refugees in need of culturally competent mental health services. The core staff reflect a wide spectrum of age groups, immigrant/refugee cultural status and language fluency in 13 A&PI languages/dialects: Cambodian, Cantonese, Japanese, Khmuu, Korean, Lao, Mandarin, Malay, Mien, Tagalog, Thai, Toishan, and Vietnamese. Each year, ACMHS serves over 3,000 A&PI clients from Alameda and Contra Costa counties.

Since 1996, APPS is dedicated to improving the quality of life for the historically underserved Asian and Pacific Islander communities living in the East Bay Area. Offering services and expertise that are sensitive to language, cultural needs, and the experiences of our clients, APPS provides behavioral health care to individuals, families and communities of Asian and Pacific origins, with offices in Oakland, Richmond and Brentwood, CA. APPS' services include: *adult mental health and alcohol/drug prevention and treatment; domestic violence intervention and prevention; EPSDT mental health and AOD prevention and treatment; AOD/MH treatment for court-referred and other youth; EPSDT wraparound services; a community mobilizing AOD prevention program; and youth development*. Over 90% of APPS' adult consumers need to be served in their native language. APPS staff reflects its consumers' diversity, and provides services in 12 Asian languages and dialects. APPS values that shape our services are: Wellness, recovery and resiliency; Consumer-driven services for adults; family-driven services for children; Cultural competency embedded in program and service delivery design; Delivery of services and supports through Integrated Service Teams Community involvement that is promoted and developed.

SECTION II - DATA SOURCES: The recommendations in this report are based on data collected through community focus groups and surveys conducted in 2005 and 2007. Interviews and focus groups were conducted with mental health providers, community-based organizations and other health and social services providers who work in agencies that serve Asian communities in Alameda County to gather information on systems issues and unmet needs. Some agency providers that serve non-Asian immigrant groups were included in the interviews to identify common issues across communities. A survey of agencies serving Asian communities in Alameda County was conducted to gather information on issues relating to outreach and referral. Focus groups were also conducted to gather specific information on unserved (Tongan, Burmese) and underserved (Cambodian) API communities. Agencies that serve API communities were convened to give input into the proposed strategies. The findings are summarized in detail in the attached report (See Attachment C). Key findings, relevant to PEI, are included in the next section.

SECTION III - RECOMMENDATIONS:
The recommendations address meeting the PEI needs of userved and underserved API populations of all ages. There is a particular focus on children/youth from stressed families and an emphasis on a family approach that involves parents, grandparents and other members of the extended family.

Disparities in Access to Care - Several Asian and Pacific Islander (API) communities are underserved, and have very limited access to mental health services. This includes Cambodian, Chinese, Filipino, Japanese, Korean, Lao, Mien, and Vietnamese communities. For these communities, some mental health services already exist and there is a structure of non-mental providers that can serve as gateway for mental health services (CBOs, faith-based, primary health care, traditional healers, youth development programs, etc.) Some of the smaller and emerging API communities are unserved and have virtually no access. For these communities - Burmese, Mongolian, Thai, Tibetan, Samoan, Tongan and other Pacific Islanders – There are no formal mental health services and minimal structures of other providers except for some churches/temples.

One of the key factors that impacts access to care is a gap – or *cultural dissonance* - between how API communities view health/mental health and illness and the structure of the mental health system. The key systems barriers include: 1) lack of culturally and linguistically appropriate services, particularly those that are geographically accessible to API communities; 2) lack of integration of mental health into services or programs that are utilized by APIs. These services/programs include recreation centers, schools, after school programs and youth development programs, faith

organizations, primary health care and other community-based organizations. The key community barriers include: 1) stigma surrounding mental illness and mental health services; and 2) lack of community readiness and knowledge about mental health. Some unserved communities also lack a strong community infrastructure for spreading information and providing support.

At-Risk Children, Youth and Young Adult Populations – Focus groups and surveys revealed several issues that impact young APIs, including intergenerational/cultural conflict, unstable home life with many people living under one roof, difficulty expressing themselves and adjustment issue, parents suffering from mental health issues and/or PTSD, which affects children, witnessing violence in the home or on the streets and gender expectations. Some specific issues impacting different age groups include:

- Children - 0-5 , sleeping and feeding disorders, separation anxiety and bonding problems, aggressive/agitated behaviors, delay in language and social/emotional skills
- Teens - anger, truancy, depression, court-ordered service because of stealing, aggression, violence/exposure to violence, AOD; referrals for those with suicidal ideation or attempted suicide, oppositional defiant disorder, PTSD, trauma, self-mutilation, lack of information about sexuality
- Transition aged youth - Higher rates of depression and domestic violence because of AOD use, unemployment stress, early parenthood

Community Capacities and Strengths – Key community strengths cited include: resilience in overcoming adversity and adapting to new environments, connection to cultural heritage and practices, community networks with strong partnerships (except for unserved communities), bilingual/bicultural services for some communities including APPS, ACMHS and other providers, friendship networks among youth and strong faith communities. It was also noted that API communities tend to value family, elders, education and volunteerism and that some communities have strong informal social support networks. Ethnic media is a strong vehicle for communication in some API communities.

Proposed Approach - We propose to create bridges between API communities and mental health services by locating PEI services in community sites routinely frequented by API communities and integrating PEI services into community services and activities. Community organizations would serve as partners in the continuum of outreach, referral, screening and assessment in addition to providing education, development, support and counseling for youth and parents. Mental health professionals and paraprofessionals, situated in community sites would strengthen linkages between community settings and mental health services and strengthen mental health and cultural competencies in different parts of the system. This integration of services will reduce barriers caused by stigma and cultural dissonance and will utilize community strengths, including the strong networks, faith communities and values. For example, a family approach will be key in addressing issues of children and youth in stressed families. Parenting classes can be used an entry points tying into strong family values. After-school programs may be used as vehicles to reach families who value education highly. These linkages will create open avenues to conduct education and build trust and relationships with underserved/unserved community members. In addition, targeted strategies will be aimed at building community capacity in unserved communities, specifically increasing social supports and readiness for mental health services. This approach is depicted in the attached logic model (See Attachment B).

Systems Level Recommendations: Strategies are aimed at integrating PEI activities within non-mental health organizations in the API community. They are also aimed at increasing the cultural competence of non-API health and mental health providers and public systems (probation, schools, recreation centers, etc.)

- Increase mental health competencies and knowledge of API MH resources among API serving organizations and API community leaders
- Increase integration of services between MH and community sites frequented by API community members
- Collaborate with community partners in outreach, referral, screening and assessment
- Integrate MH with other health and wellness services (primary care providers, traditional healers, faith leaders, etc.) to bridge the gap between MH and community health-seeking behaviors
- Conduct cultural competency and cross-cultural communications training for mental health and community providers

Systems Outcomes:

- Increase in number of API serving organizations with a formal process for identifying individuals/families with social, emotional, and behavioral issues
- Increase ability of API serving organizations to appropriately identify, refer and/or serve API communities

Community Level – In addition to a universal strategy, aimed broadly at underserved and unserved APIs, there will be targeted efforts focusing in unserved API communities.

Universal strategies include:

- Conduct education, including use of traditional media (TV, news, radio), new media (internet, social networking, telecommunications, video-, audio clips and pod casts),
- Partner with existing programs (youth development, academic, adult and teen health clinics, etc.) to integrate community mental health workers among their program staff to build trust and rapport with consumers in a non-stigmatizing environment.
- Partner with existing programs to strengthen the continuum of parent education, support and counseling
- Identify and work with community gate-keepers to create opportunities for community outreach and education

Outcomes:

- Increased knowledge of risk and resilience/protective factors among underserved and unserved API communities
- Increased resilience and protective factors among underserved and unserved API communities
- Increased knowledge of social, emotional and behavioral issues among underserved and unserved API communities
- Reduced family stress/discord among underserved and unserved API communities
- Improved mental health status

Targeted strategies acknowledge the lack of community infrastructure to address mental health needs and include:

- Strengthen social support networks in unserved API communities
- Strengthen community readiness for MH services in unserved API communities

Outcomes:

- Increased social support for unserved APIs with MH needs

Implementation – The different levels of community infrastructure must be recognized in implementing the strategies identified above. Three strategic strands are proposed:

Universal approach – Hire mobile staff to conduct education campaigns and train local community leaders and providers in different sites to integrate education, outreach, referrals in their programs and activities.

Underserved communities - Place mental health professionals in existing community sites (e.g. CBOs, faith-based institutions, primary health clinics, recreation centers).

Unserved communities - Hire mental health professionals/ paraprofessionals *from those communities* (paraprofessional does not have a masters in one of the mental health/social work fields). Workers will be stationed at least part of the time at recognized gathering centers (church, temple, others to be identified through focus groups).

The proposed strategies will have the long-term impacts of enhanced wellness and resilience, earlier access to MH services, lower incidence of mental illness and reduced stigma. Furthermore, the result will be an increase in the number of individuals and families from underserved populations who receive prevention programs and EI services.

ATTACHMENTS

Organizations that Participated in the Development of this Report

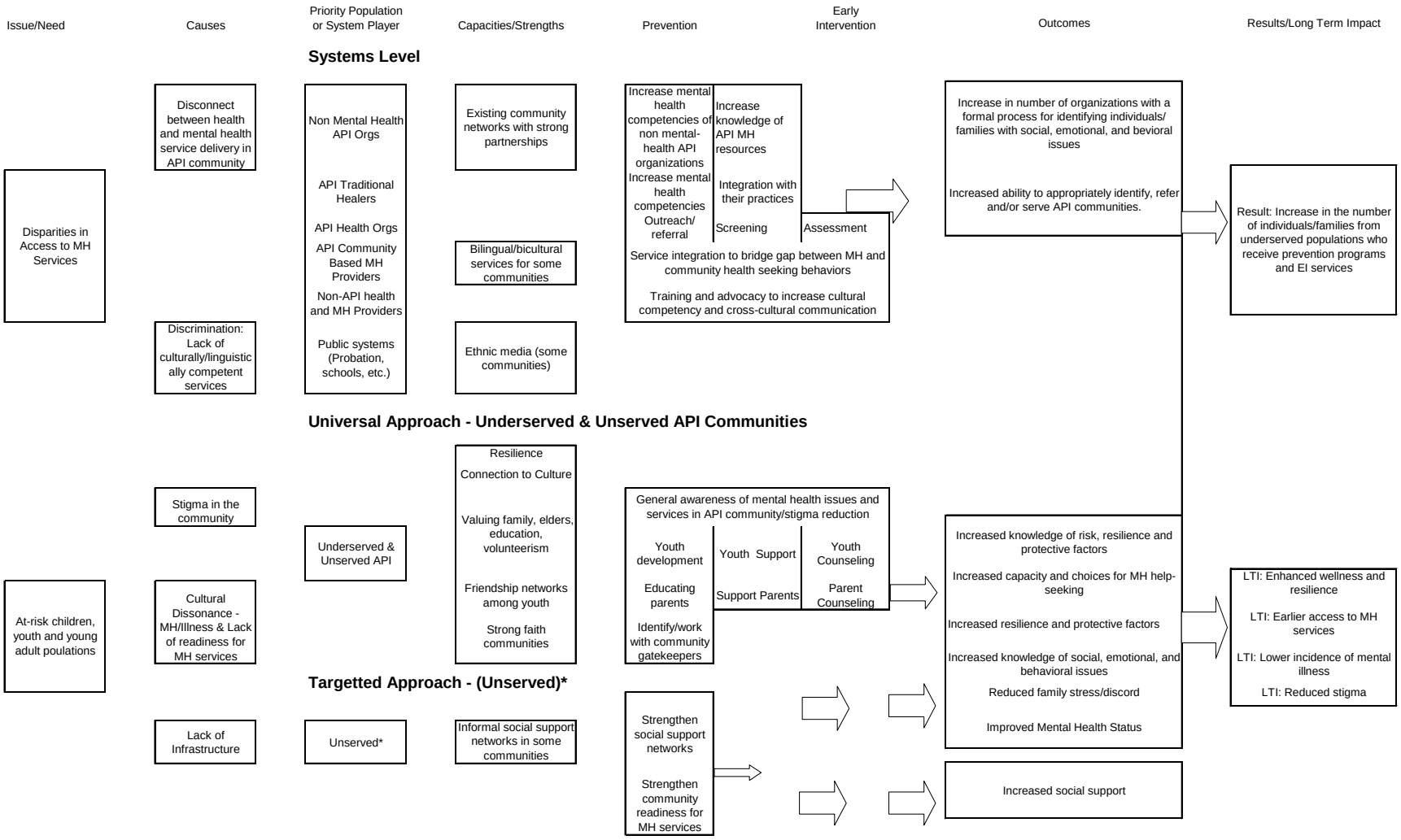
Report Preparation:

- Asian Pacific Psychological Services (lead agency)
- Asian Community Mental Health Services

Community Input Meeting:

- Asian Health Services
- Filipinos for Affirmative Action
- Korean Community Center of the East Bay
- Oakland Unified School District
- OASES

Logic Model for API Communities PEI Recommendation



*Burmese, Mongolian, Thai, Tibetan, Tongan, Samoan, Other Pacific Islanders

Asian Americans and the Alameda County Mental Health System Report and Recommendations for Implementation of the Mental Health Services Act Revised - December 2007

(for MHSA PEI Planning)

Original report
Prepared by:
Asian Community Mental Health Services
Asian Pacific Psychological Services
Culture to Culture Foundation
Made possible through a grant from Asian Pacific Fund
October 2005

Revised Report
Prepared by:
Asian Pacific Psychological Services
Asian Community Mental Health Services
made possible through funding from
Alameda County Behavioral Health Care Services
December 2007

Written by: Laurin Mayeno, MPH, Consultant

Contents

Asian Americans and the Alameda County Mental Health System
Report and Recommendations for Implementation of the Mental Health Services Act
Revised – December 2007

I. Introduction

The purpose of the original report in 2005 was to inform Alameda County Behavioral Health Care Services (BHCS) in its plans to transform the system through the Mental Health Services Act. This report has been revised to include information that is particularly relevant to Prevention and Early Intervention. In addition, information has been added based on focus groups conducted in 2007.

Methodology – This report utilizes data from several sources. Data were collected to supplement available information through the following methods:

- Interviews and focus groups with mental health providers, community-based organizations and other health and social services providers who work in agencies that serve Asian communities in Alameda County to gather information on systems issues and unmet needs. Some agency providers that serve non-Asian immigrant groups were included in the interviews to identify common issues across communities. Additional focus groups conducted in 2007 include the Burmese, Cambodian and Tongan communities and API serving agencies
- A survey of agencies serving Asian communities in Alameda County to gather information on issues relating to outreach and referral (see Attachment 1).
- A survey of Asian consumers and caregivers, conducted in 2005[i]. This set of information was supplemented by other data sources, including: 1) utilization data from Alameda County Behavioral Health Care Services; 2) U.S. Census data; 3) data on insurance rates on County and State Levels. Steering committee members also reviewed the report and provided input and information.

Limitations of existing data – BHCS has estimated prevalence for seriously emotionally disturbed (SED) and severely mentally ill (SMI) individuals in Alameda County who are below 200% of poverty. Data are also available for clients served and type of service. These data are broken down by major racial/ethnic groups and regions of the county, as well as some age groups. However, disaggregated data on Asian and Pacific Islander groups are not available. Assessment of API ethnic groups versus APIs overall is essential to identifying the underlying causes to significant needs within each community (e.g., high poverty rates, linguistic isolation, and lack of health insurance). Data that are not currently available from the county include: specific ethnic and language groups within the Asian and Pacific Islander population, or citizenship status, or specific mental health needs of these groups. Furthermore, there are limited data on

the cultural and language capacity of service providers within the county mental health system.[1]

Limitations of this report – This report focuses primarily on communities with large immigrant and refugee populations and does not address mental health issues that impact Asian Americans who have been in the U.S. for several generations, including the large population of biracial and multiracial Asians. Since the Asian population in Alameda County is very diverse, the data collection methods aimed to include, as much as possible, the diversity of communities.

This report does not include cover all Asian ethnic groups in Alameda County or provide in depth information for any one subgroup. This report has limited information about Pacific Islander communities who face issues that are both similar and different to those faced by Asian communities. Although some information on these groups is included, further assessment is needed to understand the unique needs of these communities.[2]

II. Disparities in Access to Mental Health Services

The Asian and Pacific Islander population in Alameda County is growing and extremely diverse. Attachment 2 shows census data for ethnic subgroups. Between 1990 and 2000 there was a 60% increase in the Asian population (not including Asians in combination with other groups) and a 14% increase in the Native Hawaiian and Pacific Islander population. A majority of Asians (64%) are foreign-born. These populations who are limited English proficient are vulnerable to postponing needed health and social services due to difficulty communicating in English and understanding how to navigate the system. This section examines available data on prevalence and utilization and discusses key groups that are underserved based on age, ethnicity/language, geography and insurance status.

Underutilization of Services

The tables below are based on data provided by Alameda County Behavioral Health Care Services (BHCS). In these data Asians and Pacific Islanders (API) are grouped together in one category. Table 1 demonstrates that Asians and Pacific Islanders[3] under 200 percent of poverty with Serious Emotional Disturbance (SED) and Severe Mental Illness (SMI) are underserved compared to the total population. While 39% percent of the total population with SED/SMI is unserved, 65% of the API population or (3,918 people) with SED/SMI is unserved. This means that nearly 2 out of every 3 API individuals with SED/SMI is unserved. These data demonstrate, that low utilization of services by API

[1] The California Asian Mental Health Network has compiled a directory of Asian mental health providers in the Bay Area. This directory is available at www.asianmentalhealth.info.

[2] Native Hawaiians and Pacific Islanders communities have unique characteristics and needs, which are often very different than those issues that impact Asian immigrant and refugee communities.

populations is not indicative of a low level of need, but rather a high level of unmet need. This unmet need is due to a variety of systems factors, as well as some community factors, which are explored further in later sections of this paper.

Children and Youth - The rate of disparity is most glaring for children and youth. Asian youth are three times as likely to not be served as youth of all other races. Among API children and youth, the largest percentage of the prevalence population is served in outpatient services (16%), while much smaller percentages are served in school (9%), Level 3 (8%) and day treatment (2%). Less than 1% receives wraparound and residential services.

Table 1: Estimates of Prevalence of Persons with Serious Emotional Disturbance (SED) and Serious Mental Illness (SMI)

Persons < 200% poverty					
	Prevalence	Served	Unserved	Served as % of Prevalence	Unserved as % of Prevalence
All ages					
Total	29504	17907	11597	61%	39%
API	5989	2071	3918	35%	65%
Youth 0-17					
Total	9120	6872	2248	75%	25%
API	1645	452	1193	27%	**73%**
Adults 18 and older					
Total	20384	11035	9349	54%	46%
API	4344	1619	**2725**	37%	63%

Adults and Older Adults - The largest number of unserved API people with SED/SMI is among the adult population (2,725). Table 2 shows that when the adult population is broken down by age, older adults are severely underserved. The percentage of API older adults unserved (73%) is similar to the percentage for the total population (74%). While the need is significant for Asian older adults, particularly since older Asian American women have the highest suicide rate of all women over 65 in the U.S. (US DHHS, 1999), there are limited programs to serve this population.

Table 2: Estimates of Prevalence of Persons with Serious Emotional Disturbance (SED) and Serious Mental Illness (SMI) –Breakdown of adults by age group

Persons < 200% poverty					
	Prevalence	Served	Unserved	Served as % of Prevalence	Unserved as % of Prevalence
18-59					
Total	17387	9051	8336	52%	48%
API	3673	1331	**2342**	36%	64%
60+					
Total	3057	788	2269	26%	74%

API	671	184	487	27%	**73%**

Ethnic/Language Groups

The groups most often cited as having unmet needs are recent immigrants and refugees. Some recent immigrants lack community gathering-places to obtain information about services. In addition to facing language and cultural barriers, many recent immigrants are unfamiliar with Western concepts of mental health and have difficulty navigating the bureaucracy of the mental health system. Refugee populations from Southeast Asia and the Middle East are at high risk for mental illness due to the trauma experienced by war and resettlement.

According to U.S. Census data, 63% of Asians and 30% of Native Hawaiian and Pacific Islanders (grouped together in one category in data) are foreign born. Attachment 3 shows that rates of foreign born among all Asian subgroups except for Japanese range from 62% (Laotian) to 77% (Pakistani).

Poverty rates vary significantly amongst the different Asian and Pacific Islander subgroups, which influences need and eligibility for county mental health services. Attachment 4 shows that the percentages above 200% of poverty are highest among refugee groups, including Cambodian, Laotian and Vietnamese communities. Bilingual/bicultural provider access is a critical issue for Asian immigrant households. Based on our focus group and structural interviews, the Alameda County mental health system only has a few Chinese and Filipino providers at emergency crisis but no other points of access (e.g., mobile crisis, clinics). The bilingual/bicultural Asian & Pacific Islanders that do exist are only available on an outpatient basis (e.g., ACMHS and APPS in North County). Because there is a lack of bilingual/bicultural services throughout most of the mental health system, children of immigrants also have difficulty accessing care because the system lacks capacity to communicate with their parents. Table 3 shows that many Asian and Pacific Islander ethnic groups have high rates of linguistic isolation[4], limited English proficiency and high percentages of individuals who speak a language other than English in the home.

Table 3: Language Data for Asian and Pacific Islander Groups in Alameda County, 2000

Population Groups - Alameda County, California	Population	Linguistically Isolated Households	Speaks English Less Than Very Well (LEP)	Speaks Other Than English At Home
Total Population	1,443,741	9%	18%	37%
Asian Total	295,218	25%	38%	78%
Asian Indian	42,842	10%	24%	87%

[4] Linguistic isolation refers to households in which no individual over the age of 15 speaks English fluently.

Cambodian	3,533	27%	49%	91%
Chinese, except Taiwanese	108,751	36%	49%	82%
Taiwanese	**3,255**	**40%**	**57%**	**93%**
Filipino	69,127	10%	23%	66%
Indonesian	784	16%	30%	71%
Japanese	12,540	14%	16%	35%
Korean	14,217	32%	44%	79%
Laotian	**3,438**	**38%**	**56%**	**94%**
Pakistani	2,019	8%	21%	90%
Thai	1,198	28%	38%	72%
Vietnamese	**23,817**	**44%**	**59%**	**93%**
NHOPI Total	9,142	5%	17%	54%
Samoan	1,508	2%	23%	65%
Tongan	1,558	11%	36%	84%
Fijian	1,576	12%	27%	89%

Source: U.S. Census Data compiled by Asian Pacific Islander American Health Forum, www.apiahf.org

There is a shortage of mental health professionals for all Asian languages. The greatest unmet need is among those ethnic/language groups for whom there are the most severe shortages of mental health professionals and paraprofessionals. For example, both Tongan and Burmese focus group participants mentioned lack of services available to their community and not knowing where to go for care (See Attachments 6 & 7). Some of these groups have immigrated to the county within the last 5 years and are not counted in 2000 census data. According to focus groups and interviews, these include:

- South Asian: Hindi and Punjabi
- Middle Eastern (spoken by refugees from Afghanistan): Pashtu and Dari
- Southeast Asian: Burmese, Khmuu, Mien and Thai
- Pacific Islander: Tongan and Samoan
- East Asian: Mongolian and Tibetan

Geographic Areas

Several areas outside of Oakland have unmet need as a result of geographic barriers. The majority of bilingual/bicultural mental health services for Asian Communities are located in Oakland (North County). Transportation from East South North County is often difficult and time consuming. Furthermore, many recent immigrants have difficulty navigating the public transportation system, due to language barriers, lack of familiarity with the area and inexperience with the transportation system.

Table 4 shows that East and South County have the highest percentages of unserved adult populations, for both the total population and APIs. The older adult populations have the highest percentage of unserved in East County (90%) and South County (87%).

Table 4: Summary of Clients Served as Percent of Estimated SMI/SED Prevalence Population, By Age Group, Ethnicity and Region

	North		Central		South		East	
18 +								
Total	6276	49%	2227	54%	963	38%	373	40%
API	1020	36%	259	38%	207	28%	29	31%
18-59								
Total	5809	52%	1981	60%	908	43%	353	41%
API	889	37%	226	39%	188	31%	28	34%
60+								
Total	467	28%	246	31%	55	12%	20	13%
API	131	30%	33	35%	19	13%	1	10%

North – Alameda, Albany, Berkeley, Emeryville, Oakland, Piedmont
Central – Ashland, Castro Valley, Cherryland, Hayward, San Leandro, San Lorenzo
South – Fremont, Newark, Union City
East – Dublin, Livermore, Pleasanton, Sunol

Uninsured

Another group that lacks access to care is the uninsured. This includes people who are considered "working poor". Their incomes are too high to qualify for MediCal, and too low to afford private insurance. In addition, many Asians do not qualify for, or are fearful of applying for MediCal due to immigration reasons. The following chart shows that insurance rates for Asian populations vary widely.[ii] California data are provided for Asian children, as these data are not available on a county level.[iii] Data are not available for all Asian subgroups.

Table 5: Insurance Rates for Selected Asian and Pacific Islander Groups

Race and Ethnic Group	Uninsured all or part of year		MediCal or Healthy Families All Year
	Alameda County Adults 2000	California Children 2001/2003	California Children 2001/2003
Asian American and Pacific Islander	15%	9.0%	20.4%
Chinese	14%	6.9%	19.3%
Filipino	8%	7.8%	13.1%
Vietnamese	27%	9.4%	42.1%
Korean	20%	27.7%	16.7%

South Asian	---	***	13.6%
Japanese	---	---	5.8%
South Asian & Japanese*	6%	***	---
Native Hawaiian/Other Pacific Islander and Other Asian*	20%	---	---
Other single or multiple Asian group	***	9.0%	31.5%

*Grouped together due to small sample size
***insufficient data for estimates
--- data not provided in this group

III. At Risk Children, Youth and Young Adult Populations

The following sections provide more detail on issues that have a particular impact in specific children and youth.

Children and youth of all ages

- Intergenerational/cultural conflict
- Unstable home life with many people living under one roof
- Difficulty expressing themselves and adjustment issues
- Parents suffering from mental health issues and/or PTSD, which affects children (especially among Southeast Asian communities)
- Exposure to community violence and domestic violence in the home

Children - 0-5

- Sleeping and feeding disorders
- Separation anxiety and bonding problems
- Exposure to violence
- Aggressive/agitated behaviors
- Delay in language and social/emotional skills

Teens

- Anger, truancy, depression, court-ordered service because of stealing, aggression, AOD; referrals for those with suicidal ideation or attempted suicide
- Oppositional defiant disorder, AOD, PTSD, trauma – part of or witnessing violence on streets, domestic violence, self-mutilation
- Lack of information about sexuality

Transition aged youth

- Higher rates of depression and domestic violence because of AOD use, unemployment stress, etc.
- Inability to find employment often because of criminal records and lack of education

- Early parenthood - Laotians have the highest teen pregnancy rate in California (estimates range from 8.7% - 19%, not including early termination of pregnancy that don't show up in the statistics. Could be as high as 30% if these are included).
- AOD – Smoking marijuana and drinking are the norm. Methamphetamine use is on the rise in the API community.
- Intergenerational conflict has a significant impact at this age because parents and youth may have conflicting expectations as youth makes major life decisions.
- Gender expectations also play a role. Girls often have less freedom than boys and are expected to assume more responsibility in the home or family business.

Barriers to Care and Systems Issues

Among children and youth, the group most often cited as having unmet need are children whose parents are recent immigrants and speak a primary language other than English. In school-based settings without multiple language capacities, it is often difficult to communicate with the parents in a timely way to obtain consent for their child to receive mental health counseling. Furthermore, immigrant parents are often busy working in order to meet the family's survival needs and have limited flexibility to focus on their children's mental health needs. The following are barriers to care and systems issues that impact Asian children and youth of all ages:

- **Fragmentation and follow through -** Youth referrals seldom work unless a provider accompanies the child/youth. The system is segmented so that a child or youth is treated and the family is not. It is difficult for clients to understand why the needs of the family are not served in the same place.
- **Communication with families** - Asian providers are often called upon to assist with bilingual/bicultural communication with families. However, there is no reimbursement for this service. There is often a failure to establish a strong connection with the family after the referral is made. Families may not follow through with appointments if they find out that the referral is not in a familiar location or that bilingual staff is not available.
- **Lack of screening, referral and diagnosis –** Children/youths are not referred for appropriate services. Due to a lack of early intervention, children/youth often receive care only after they have a serious psychotic breakdown.
- **Mistrust of the system** – Mistrust of the mental health system is common in Asian communities and is often linked to cultural dissonance (discussed in previous section) or negative community experiences with government organizations. For example, parents sometimes avoid contact with the system for fear that their children will be taken away from them. Due to mistrust, and lack of knowledge about mental health, parents may not be receptive to seeking or allowing treatment for their children. Cultural differences may also be a barrier. For example, if parents will not utilize mental health services if they don't perceive the problem their child is struggling with as mental health issue.
- **Provider awareness-** Provider awareness of mental health issues and their impact in the Asian community may be limited. For example, mental health practitioners not always aware of the legal implications of their work. In addition to providing

services, they are often in a position to make assessments that can impact the rest of a child's life.

School aged children and youth

- **Parental consent** - Parental consent is required, with few exceptions, for minors get counseling services. Delays in obtaining parental consent, due to difficulties communicating with families, result in delayed services, even when services are provided at the school site.
- **Lack of referral/support from schools** – Young people have to fail at everything in order to get services, even when they are truant. A young person can get caught with marijuana and be suspended several times before receiving a referral. There is insufficient buy-in on the part of school staff and incentives are lacking to motivate teachers to support counseling.

Teens

- **Youth-friendly services -** ACCESS is not child friendly. If a youth is age 12 or older, he/she can self-refer for drug and alcohol treatment. Staff is often unfamiliar with youth and inner city culture and the neighborhoods in which many youth live.
- **Parental engagement –** In general, adolescents are harder to engage. Cultural differences also make Asian youth harder to access. For example, in the Mien and Cambodian cultures, there is no adolescent period comparable to adolescence in the West. So when a youth starts misbehaving there is less parental engagement.
- **Lack of insurance -** Teenagers are more likely to be uninsured than younger children.

Transition age youth

- **Location of services** - Some residential services for transition-aged youth are out of the county.
- **Insurance -** Limited medical enrollment - Youths are easily disqualified for MediCal when they begin earning an income. For example, one young woman was transitioned out of the child system after having established a relationship with APPS for many years. When she started working part time, she no longer qualified for MediCal. The agency negotiated to provide counseling on a sliding scale and absorbed the additional cost of care ($80/session). Even when paying a fraction of the cost ($20/session), the client felt she could only afford one counseling session per month.
- **AOD treatment** – There is a lack of AOD treatment resources for young adult Asians.
- **Attitudes toward mental health services –** Asian men tend to avoid preventive health resources (like men in the general population). They also tend to have a negative attitude towards mental health care.

IV. Factors that Impact Access to Prevention and Early Intervention Services

Cultural dissonance between systems and community concepts of mental health - An overarching concern that came up in interviews and focus groups is that

the conceptualization, language and structure of mental health in the U.S. are in conflict with the ways that many Asian cultures think about, talk about and address these issues. The language of mental health is completely foreign to some communities, and may be a deterrent for seeking care. Barriers exist in the interaction (or lack of interaction) between systems and community.

Systems - Level Factors

Outreach & referrals - In exploring the issue of underutilization of care by Asian communities, it is important to examine the system of community linkages and referrals. Among the community organizations surveyed, the majority referred patients directly to community-based mental health services (ACMHS 62.5% and APPS 50%) and Behavioral Health Care Services 62.5%.

According to the providers interviewed, the most common sources of referrals for all age groups are:

- **Health care providers** –Private providers, hospitals, and health centers may identify mental health issues among patients whose symptoms may appear as physical health issues. Hospitals also refer people from the emergency room in the case of suicide attempts.
- **Criminal justice system** – Individuals are often referred by the courts, police or probation when a mental health issue is identified or in response to a domestic violence situation.
- **Community-based organizations** – CBOs that provide services such as domestic violence, legal services, community development and family support often identify mental health issues among their clients and refer them for services.
- **Emergency psychiatric services** – Some individuals are referred for services after having a crisis situation such as a serious psychotic breakdown.
- **Social services** – Individuals are often identified when they apply for CalWorks or SSI.
- **Community members –** Friends and family members sometimes refer clients for services.
- **Mental health providers** – Providers often refer family members of existing clients for services. In addition, providers who cannot meet the demand for their services refer people seeking care to other providers.
- **ACCESS Program** – ACCESS is sometimes a source of referrals. However, participants stated that they receive few referrals through this program and are often contacted directly.

There are some significant differences in how children and adults are referred. Schools and early childhood programs play a major role in identifying and referring children and youth for mental health services. School psychologists, teachers, administrators and student study teams (SST) are a significant source of referrals for children and youth. Furthermore, staff from both ACMHS and APPS work within the schools, to make their services more directly accessible. Truancy boards are also a source of referrals for

youth. Preschools, Head Start programs and other early childhood programs are also a source of referrals for young children.

Child Protective Services is a source of referrals for children and occasionally refers parents of children for services; Adult Protective Services is a referral source for adults.

The following characteristics help referrals work:

- **Relationships/trust -** A community agency has an ongoing relationship and established trust with an individual or family.
- **Trained staff -** Referral agencies have individuals on staff trained to recognize signs of mental illness and knowledgeable about how and where to make referrals. For example, some community agencies have social workers on staff and/or people who provide case management or referrals.
- **Interagency linkages and language capacity** - There is a relationship between staff members from the referral agency and the mental health agency, and both agencies have language and cultural capacity to work with the individual and or family. There is follow-up to ensure that individuals enter into care.
- **Available, appropriate services** - There are culturally and linguistically appropriate services that are available in a convenient location in a timely way.

The following limitations of the referral system were identified:

- **Referrals -** Some providers reported that referrals don't always happen when they should. Schools often fail to make referrals even after children are caught with marijuana and suspended. Teachers are caught between pressure to "teach to the test" and the mental health needs of the child and are reluctant to excuse children from classes. Medical providers often overlook signs of mental illness (see previous section on cultural dissonance) or subscribe anti-depressants rather than referring individuals for mental health services.
- **Follow-up -** Some individuals reported that they don't know what happens after they make a referral. There is no follow-up to ensure entry into care. Clients often get lost between the referral and entry into care.
- **ACCESS as gatekeeper** - One provider stated that the role of ACCESS as a gatekeeper provides a barrier to getting clients into care. Before ACCESS was established, clients could go directly to the agency for services.
- **Appropriate providers -** Several individuals reported that they could not identify an appropriate provider to refer to. Language/cultural capacity, geographic barriers and lack of insurance were sited as reasons that referrals were not made. Others stated that providers would not accept MediCal or MediCare.
- **Information -** The majority of the community organizations surveyed (60%) reported that they do not receive information about mental health services in Alameda County. Only 10% received information about how to make referrals and how to recognize signs of mental illness.

Structure of mental health system – The challenge of cultural dissonance extends beyond the individual interaction with patients and providers and is rooted in the structure of the mental health care delivery system. Participants in interviews and focus groups stated that the medical model, designed primarily around therapy and medication for individuals, is inappropriate for meeting the needs of Asian communities. Furthermore, they stated that the system of treating different family members in separate locations from one another was a barrier to retention. Important to note is that the majority of ACMHS and APPS clients do not come voluntarily (e.g., court referral, court ordered, or family brings them as a last resort during a crisis situation).

Language/cultural barriers - Seventy-two percent (72%) of respondents to the Consumer and Caregiver survey indicated that they had difficulty finding appropriate mental health providers due to language barriers. Asian households have the highest levels of linguistic isolation in Alameda County. Language and cultural capacity of service providers was also the most frequently mentioned issue in focus groups and interviews conducted with providers.

The lack of providers with language and cultural capacity throughout the system can present insurmountable barriers to meeting the mental health needs of Asian immigrant and refugee communities. Mental health interactions require both an ability to communicate in the language of the family and an understanding of the ways that mental health issues are expressed and understood in the different Asian cultures.

Unserved languages – Focus group participants and interviewees stated that needs have arisen for services in the following languages not served at all by the county system:

- South Asian: Hindi, Punjabi
- Middle Eastern (spoken by refugees from Afghanistan): Pashtu, Dari
- Southeast Asian: Burmese, Thai
- Pacific Islander: Tongan and Samoan
- East Asian: Mongolian, Tibetan

Community-based mental health providers – Participants in focus groups and interviews stated that a strength of the current system is the presence of community-based providers, such as Asian Community Mental Health Services (ACMHS) and Asian Pacific Psychological Services (APPS), contracted by BHCS, to provide services to Asian communities. In many cases, these agencies may have only one or two staff members who speak a particular language. Many of their staff members, particularly from Cambodian, Lao[5] and Mien communities, report that there are not enough staff members to meet the needs of the communities. Even when language providers are found, because of budget constraints, they turn over rapidly because of inability to

[5] "Laotian" includes all refugees and immigrants from Laos. The lowland Lao are the dominant ethnic group culturally and politically. Other significant groups include: Mien, Hmong (not many in the Bay Area), Tai Dam, Lue, Khmuu, Lahu. "Lao" also refers to the language spoken by the lowland Lao.

adequately compensate them or offer a longer-term career path. The system allows these organizations the flexibility to hire paraprofessional staff members from different communities to serve as part of the mental health team. These individuals bring community relationships and cultural knowledge to the team.

Community-Level Factors

Concepts of mental health - Many Asian cultures do not conceptualize issues from a mental health standpoint. For example, one provider stated that people in China who commit suicide aren't viewed as having severe depression. Rather, suicide is often attributed to the social circumstances. Individuals who would be considered mentally ill in the U.S. system are often unaware that they are ill, or do not consider their symptoms to be signs of mental illness. Conversely, providers trained in the Western model of mental health are often unable to talk about serious emotional disorders in ways that immigrants and refugees can understand.

Responses to mental health issues - When a mental health issue exists, it often manifests itself physically and individuals or families seek medical care to address the issue. When issues arise, there is a tendency for families to deal with them privately, rather than seeking care. This impacts eligibility for services, as discussed below. Care is often delayed until a crisis occurs. Symptoms of mental illness are not reported by family members or individuals in ways that are familiar to Western trained providers. The Western medical provider may treat the physical manifestations of the emotional disturbance, but do not refer clients for other necessary psychological care.

Stigma - There is a profound stigma attached to people with mental health problems in many communities. In the Consumer and Caregiver survey, 62% of responses indicated that reasons for not seeking care are culturally motivated, including religious beliefs, feeling that their problem is not serious enough to warrant seeking mental health support, or fear of evil that is associated with mental illness.

Family context – Many providers stated that their work with a particular age group requires them to interface with other family members. For example, one Mien provider who works with the 0-5 population stated "I have to work with the grandparents who usually can't speak English and have other barriers, such as lack of resources, so I have to do lots of advocating for them because they are the primary caretakers. The child's father usually is not there or is in and out or has AOD issues. Lots of case management needs to be done to serve all the generations, 3-4 generations, not just the individual because the typical Asian immigrant family is so interdependent."

Community Knowledge and Readiness - Another overarching theme from the interviews and focus groups was the need for community outreach and education. Participants reported that there is a general lack of knowledge about mental health issues in the community, as well as lack of familiarity with resources and how to gain access to them. In addition, most Asian groups are at a very early stage of community

readiness to utilize mental health services. They do not often consider using mental health services, either due to lack of knowledge or reluctance to regard these services as an option. This concern is particularly relevant for unserved communities. For example, in the Tongan focus group participants mentioned not knowing where to start in accessing services, and barriers to discussing these issues within families due to cultural taboos and a desire to keep harmony.

V. Community Capacities and Strengths

Existing Community Networks – Participants in the community feedback meeting mentioned an array of community resources that contribute to the mental health of Asian communities (See Attachment 8). These include:

- **Community-based organizations –** Agencies based in or serving the Asian community provide a range of services including English as a Second Language classes, citizenship, SSI applications, socialization, housing, job training, legal assistance, arts and culture, after school programs applications. Churches and other religious centers were also mentioned as major resources for some communities. The California Asian Mental Health Network also provides a directory of Asian Mental Health Resources. The Asian Library was also mentioned as an important resource.
- **Religious organizations** – Churches and temples are a gathering place for community members and some provide a range of activities and services.
- **Ethnic media** – Newspapers, radio and TV are a major source of information in many Asian communities.
- **Schools** - Schools are a critical partner in reaching children and youth and their parents.
- **Health organizations** - Asian Health Services was mentioned as a significant partner for referrals and primary care services. Private doctors and other health organizations are also a resource.
- **Government agencies** – Social services, CPS and police are also resources for referral and coordination of services.
- **Informal social networks –** Informal social networks may provide vehicles for reaching communities, particularly when they lack formal organizations. Some of the unserved communities have informal social networks. One youth development program staff person mentioned that friendship networks among teenage girls provided pathways for involving youth in their program.
- **Language groups served–** The following Asian language groups are served by community-based providers with professional and paraprofessional bilingual/bicultural staff members:

	ACMHS	APPS	Tri-City Mental Health
Chinese – Mandarin	X	X	X
Chinese –	X	X	X

Cantonese			
Chinese - Other dialects	X		
Cambodian	X	X	
Indonesian		X	
Japanese	X	X	
Korean	X	X	
Khmu	X	X	
Lao	X	X	
Malay	X		
Mien	X	X	
Tagalog	X	X	
Thai	X	X	
Vietnamese	X	X	X

When Asian clients need to utilize these services they often rely on their relationships with staff from ACMHS or APPS to facilitate linkages and provide interpretation. However, there is no mechanism to compensate community-based providers for this service. As a result, these agencies help to bridge the language gap for other parts of the system without compensation or bilingual/bicultural staff members are unable to respond to requests for interpretation or cultural brokering.

Resilience and Strength in Culture - It was noted that Asian immigrants have tremendous resilience to survive traumatic situations, leave their homelands and find ways to fit into and function in a new culture and social hierarchy. For example, participants in the Burmese group described having their villages burned down, miserable lives in refugee camps with no future (See Attachment 5). Young people in API communities find strength when given opportunities to connect to their cultures. This may include a range of activities from Polynesian dance classes to learning how to cook traditional dishes.

Strong Values **-** The values of protecting families, supporting community, honoring elders and educational achievement provide strength for the communities as well as potential pathways to overcome stigma around mental health services. For example, after-school programs may provide opportunities to introduce families to mental health services, in the context of protecting family and valuing educational attainment for the children. Parenting classes, when framed in the context of protecting and valuing families, may also serve as ways to provide prevention services and connect API communities to early intervention. Parents in the Cambodian focus group stated that would like to have places for their children to go after school so that they would not be on the streets (See Attachment 6). Parents in the Tongan focus group echoed similar concerns about their children and a willingness to do their part to promote their children's health and wellness (See Attachment 7). The values of supporting communities and honoring elders is reflected in a strong tradition of volunteerism. For

example, in the Burmese focus group, it was mentioned that there are volunteers who help the community and would be able to help the community more effectively if they received training on understanding the MH system (See Attachment 5).

VI. Recommendations

Unserved and Underserved API Populations

Closing the Cultural Gap - Participants in focus groups and interviews suggested that there is a need to "expand the definition of mental health to include other things that heal". Native American Health Center was sited as an example of an organization that uses alternative healing approaches such as camping, rituals, and cultural therapy. They stressed the need to broaden the service delivery model beyond a narrow medical approach to include a more comprehensive range of services. Suggestions included:

- Greater flexibility for alternative approaches for getting people into care. Utilize a psychosocial educational model, with culturally based activities. These might range from tai chi, qigong (exercises to enhance the immune system), and acupuncture to classes and walking groups for adults, camping trips and rituals and a range of vocational and cultural activities for children and youth.
- Family oriented approaches. Families should be treated and supported as a group, rather than treated individuals in isolation. For example, a team approach might involve two providers working simultaneously, one focusing on the parent and another on the child.
- Stronger linkages and integration between physical and mental health services and social services, while maintaining all aspects of care.
- Reexamine the language of "mental health" and use other terminology, when possible to avoid stigma. A suggestion was made to shift the paradigm to "behavioral health". Using terms like "classes" and "meetings" rather than "group therapy" and avoiding mental health labels on forms that patients fill out, would also help overcome stigma.
- Require training providers in cultural competence, which includes understanding how different Asian groups conceptualize and express issues of mental illness. Learn ways of communicating about mental health that are understandable and less likely to alienate Asian communities.
- Utilize partnerships with community-based organizations that have strong relationships with Asian communities as part of the service delivery model (e.g., Asian Health Services, Family Bridges).

Increasing Awareness and Decreasing Stigma - Suggestions were made for improving community awareness of mental health and mental health services as well as decreasing stigma. Other suggestions related to improving communication and follow through among providers to facilitate referrals and ensure that adequate support is required when referrals are made. These included:

Community education – Provide literature about mental health issues for populations who have access to written media. Use ethnic media such as newspapers and television. Work with churches, temples and other religious organizations. Use a variety of approaches for different groups. Websites may be an effective way to reach some communities. Provide seminars and written materials in Asian languages for parents. Participants identified key areas for community education:

- General information about mental health issues and symptoms
- Educating parents to support their children's development
- The importance of seeking care early, rather than waiting for crisis
- Removing the stigma of mental health
- How to access mental health and other services
- Helping parents connect with the school system
- Increased awareness of mental health issues that impact older adults
- Helping families understand and bridge the cultural/generation gap

Coordination/partnership among service agencies – Provide coordinated services and case management. Strengthen partnerships with organizations that serve Asian communities, including doctors, schools, CPS, social services, Asian libraries and community-based organizations. Provide training for staff members in community agencies. Establish formal programmatic partnerships between community service and mental health service agencies. Provide more personal contact between agencies. Allow time for coordination with school personnel (contracts do not allow flexibility for coordination time).

Access to care – Establish a helpline to provide information and referrals in different Asian languages. Increase bilingual/bicultural providers (see earlier section on this topic). Increase staff capacity for individual outreach, accompanying patients to services, teaching them how to take bus, etc. (see earlier section on case management and range of services). Provide early intervention services so that individuals don't have to be hospitalized before they can get care.

Children and Youth

All ages

- Treat the entire family.
- Provide support for children who witness domestic violence.
- Provide transitional coordination for children at crucial transitional points such as the first day of school/child care. Services can range from contact to more formal collaboration.

Children 0-5

- Provide support for parents in stimulating child development.

School-aged children and youth

- Strengthen relationships with schools, including coordination between school staff and mental health providers, and increase school staff awareness of mental health issues.
- Streamline the consent process to allow for more timely care.

Teens

- Provide youth-friendly programs, support groups, and sexuality education.
- Develop programs to bridge the generational cultural gap between parents and youth.
- Provide mentoring for teens with children. Staff can see them clinically for an hour a week, but they need someone else to support them on an ongoing basis.
- Educate providers on the culture of inner city youth.

Transition aged youth

- Provide AOD programs and dual diagnosis programs for young adults.
- Transitional support - Transition age youth not ready for adult system. They need intensive support when transitioning out of the child mental health system. There should be coordination with other systems, such as foster care, to ensure smooth transition

VII. Conclusion

The Asian community of Alameda County is severely underserved by the county mental health system. An estimated two of every three Asian individuals with severe mental illness or serious emotional disturbance are not being served. For children, youth and older adults three out of every four individuals is unserved. The implications of this lack of service is staggering. In addition to placing greater strain and suffering on individuals and families, it threatens the futures of children and youth, limits that chances of successful transition to adulthood, leaves women to suffer in silence from domestic violence and keeps older adults isolated and unsupported.

There is a range of community and systems factors that contribute to this situation. Community factors include stigma surrounding mental health and lack of knowledge and readiness to address mental health issues. On a systems level, critical issues to address include:

- Lack of bilingual/bicultural capacity and cultural competence
- Cultural barriers in the language and structure of mental health
- Fragmented, narrow range of services insufficient to address mental health needs and sustain continuity of care
- Barriers in eligibility criteria and processes as well as coverage for services that delay treatment or prevent access to care
- Lack of outreach, education and referral systems within the Asian community foreign born and citizenship status, in addition to poverty status and region.

Community strengths and capacities, such as resilience, community networks, faith communities and strong values provide many opportunities for partnership in overcoming barriers to foster mental health and wellbeing.

Attachment 1:

Mental Health Referrals for Asians in Alameda County
SURVEY REPORT

A survey to improve outreach and referrals for Asians with serious emotional and mental health issues in Alameda County was administered to various agencies in Alameda County that serve Asian populations. The survey questions asked staff from agencies to assess their opinions and suggestions as well as to collect quantitative data on referrals.

The survey was developed and administered by a consultant with input from Asian Community Mental Health Services, Asian Pacific Psychological Services, and Culture to Culture Foundation. The survey instrument consisted of 25 questions of varying length and type.

Agencies and staff selected to complete surveys were suggested by Asian Community Mental Health Services, Asian Pacific Psychological Services, Culture to Culture Foundation, and Narika. Fifty-five individuals from 45 agencies were contacted to complete the survey. The types of organizations contacted are as follows:

- Community and cultural centers/associations
- Community development corporations
- Environmental advocates
- Ethnic/cultural media
- Health care/public health
- Immigrant rights advocates
- Legal aid for immigrants and seniors
- Labor
- Schools, universities, and other educational centers
- Senior centers
- Social services
- Youth centers
- One elected official

The survey was produced and administered using www.surveymonkey.com. Selected agency personnel were emailed a letter along with an internet link to the survey in order to complete the survey online.

Thirty-six surveys were received, of which twenty-two valid surveys were included in the analysis. Surveys in which respondents did not answer any questions about outreach and referral were considered incomplete and thus invalid for data analysis. Also, those without organizational identifiers did not have their responses included in data analysis. Moreover, in order not to skew the data, only responses from one respondent per agency were used for data analysis. There were two valid respondents each from two different organizations. The responses of the personnel who provided more direct service to clients were selected for inclusion in data analysis.

The following are highlights from the survey results:

- Of Asian populations primarily served, Chinese (72.7%) and Vietnamese (54.5%) are the two largest ethnicities served, followed by Lao (36.4%).
- Of Asian populations primarily served, 13 (59.1%) of the 22 agencies serve three or more ethnicities. Ten agencies (45.5%) serve four or more Asian ethnicities.
- A greater percentage of the respondent agencies primarily serve adults (81.8%) and older adults (63.6%). However, 68.2% serve more than one age group.
- Thirteen agencies (65%) see Asian clients with serious emotional or mental health problems.
- Of these thirteen respondents, 84.6% refer Asians with serious emotional or mental health problems for counseling or treatment services to other agencies because their agency does not provide specialized services.
- Because a majority of the agencies surveyed serve adults, the referral load for counseling/treatment services by the nine respondent agencies predominately consists of adults (66.2%).
- No agency reported that the referral system does not work. Six (60%) of the 10 respondents reported that people sometimes get the treatment/counseling services they need.
- Of the 19 respondents, 57.9% of the agencies do have staff trained to recognize signs of emotional or mental problems in their client population.
- None of the 20 respondents would hesitate to make referrals. Only 30% would hesitate sometimes while 70% would not hesitate.
- Of the six respondents that sometimes hesitate to refer, 83.3% cite lack of services to meet language/cultural needs as a reason, followed by lack of ability to pay (50%) and no desire to seek mental health services (50%).
- Of the 20 respondents, only eight agencies (40%) receive information on mental health services in Alameda County. All of these eight agencies received information about services available. Only 2 agencies (25%) received materials about services available, how to make referrals, and how to recognize signs of mental illness.

Survey Results Summary

I. Organizational Information

Responding Organizations

1. Afghan Elderly Association
2. APEN (Asian Pacific Environmental Network)
3. Asian Pacific Islander Legal Outreach
4. Asian Health Services
5. Asian Immigrant Women Advocates
6. Bay Area Immigrant Rights Coalition
7. Center for Elders Independence
8. Culture to Culture Foundation
9. East Bay Asian Youth Center
10. East Bay Community Law Center
11. Fremont Chinese School
12. International Institute of the East Bay
13. Kaiser Permanente
14. Korean Community Center of the East Bay
15. Lali Media Group Inc.
16. Lao Family Community Development
17. LIFETIME
18. Radio Tonga San Francisco
19. The Portia Bell Hume Center

(The 3 agencies that declined acknowledgement are not listed.)

Primary Populations Served

Ethnicity	*# Agencies*	*Percent*
Afghani	5	22.7%
Burmese	1	4.5%
Chinese	**16**	**72.7%**
Cambodian	**7**	**31.8%**
Filipino	6	27.3%
Hmong	1	4.5%
Indian	**7**	**31.8%**
Japanese	3	13.6%
Korean	**7**	**31.8%**
Lao	**8**	**36.4%**
Mien	**7**	**31.8%**
Thai	2	9.1%
Vietnamese	**12**	**54.5%**
Other: Tongan	2	9.1%

Total respondents: 22

Of Asian populations primarily served, Chinese (72.7%) and Vietnamese (54.5%) are the two largest ethnicities served, followed by Lao (36.4%), Cambodian (31.8%), Indian (31.8%), Korean (31.8%), and Mien (31.8%).

Of Asian populations primarily served, 13 (59.1%) of the 22 agencies serve three or more ethnicities. Ten (45.5%) of agencies serve four or more Asian ethnicities.

Primary age groups that organization works with:

Age Groups	*# Agencies*	*Percent*
Children/youth: 0-17	11	50%
Transition aged youth: 18-24	9	40.9%
Adults: 25-64	**18**	**81.8%**
Older adults: 65 and older	**14**	**63.6%**

Total respondents: 22
Number of Agencies Serving Multiple Age Groups

# Age Groups	*# Agencies*	*Percent*
1	7	31.8%
2	**6**	**27.3%**
3	**3**	**13.6%**
4	**6**	**27.3%**
Total respondents	*22*	*100%*

A greater percentage of the respondent agencies primarily serve adults (81.8%) and older adults (63.6%). However, 68.2% serve more than one age group, and 50% of respondent agencies serve 3 or more age groups. Six (27.3%) of the 22 agencies serve all four age groups.

II. Outreach and Referral Information

The following questions and summary of responses are about services to people with serious emotional or mental health problems. This refers to people who seem to have emotional or mental health problems that are serious enough to impair their ability to function in their daily living or may be a danger to themselves or others.

Do you see people with serious emotional or mental health problems in the Asian community you serve/work with?

Yes: 13 65%
No: 7 35%

Total respondents: 20
Of the 20 respondents, 13 agencies (65%) see Asian clients with serious emotional or mental health problems.

Which groups do you most often see with serious emotional or mental health problems? (mark all that apply):

Groups Served	*# Agencies*	*Percent*
Children/youth: 0-17	4	30.8%
Transition aged youth: 18-24	4	30.8%
Adults: 25-64	**13**	**100%**
Older adults: 65 and older	**5**	**38.5%**
Limited or non-English speaking immigrants	**6**	**46.2%**
Other: Survivors of domestic abuse and their children who either witness domestic violence or are abused themselves	1	7.7%

Total respondents: 13

# Groups	*# Agencies*	*Percent*
1	4	30.8%
2	**3**	**23.1%**
3	**4**	**30.8%**
5	**1**	**7.7%**
6	**1**	**7.7%**
Total respondents	*13*	*100%*

All 13 agencies most often saw adults with serious emotional or mental health problems, followed by limited or non-English speaking immigrants (46.2%) and older adults (38.5%). Moreover, 69.2% of the respondents most often saw more than one group with serious emotional or mental health problems.

Does your agency ever refer Asians with serious emotional or mental health problems for counseling or treatment services to other agencies because your agency does NOT provide specialized services?

Yes: 11 84.6%
No: 2 15.4%

Total respondents: 13

Where does your agency refer people for counseling or treatment? Please mark all that apply:

Provider	# Agencies	Percent
Alameda County ACCESS Program	3	27.3%
Asian Community Mental Health Services	**6**	**54.5%**
Asian Pacific Psychological Services	**7**	**63.6%**

Alameda County Medical Services: Highland Hospital	**5**	**45.5%**
Psychiatric Emergency Services, e.g. John George Psychiatric Pavilion Hospital	3	27.3%
Private mental health provider	4	36.4%
Medical doctors	4	36.4%
School psychologist, teacher	3	27.3%
Religious leader, church or temple	**5**	**45.5%**
Traditional Healer	0	0%
Other: Peer support session*	1	9.1%

* "For non-serious cases, we have built into our youth program a 'peer support' session with a licensed counselor; eventually the youth can run the sessions themselves with a facilitator."

Total respondents: 11

Among the 11 respondents, 63.6% referred to Asian Pacific Psychological Services, followed by Asian Community Mental Health Services (54.5%), Highland Hospital (45.5%), and a religious leader or institution (45.5%).

Number of Agencies Referring to Multiple Providers

# Providers for Referral	*# Agencies*	*Percent*
2	2	18.2%
3	**5**	**45.5%**
4	1	9.1%
5	1	9.1%
6	1	9.1%
7	1	9.1%
Total respondents	*11*	*100%*

All of the agencies had more than one provider to which to make referrals. Five (45.5%) of the 11 agencies refer to three different providers.

For questions 5 through 9, there were a total of 11 respondents (none skipped). However, as two of the agencies replied with "not sure" or "unknown," only the nine agencies with data will be included in the data analysis.

	Children/Youth	Transition Aged Youth	Adults (25-64)	Older Adults (65 and older)	
Agency 1		5	10		15
Agency 2			25	60	85
Agency 3	1		1	1	3
Agency 4	200	10	1200	250	1660
Agency 5	21	2	18	5	46
Agency 6			20	70	90

Agency 7	3		3		6
Agency 8	5	25	15	5	50
Agency 9			5		5
	230	*42*	*1297*	*391*	***1960***

Approximately how many children/youth (ages 0-17) are referred out for counseling/treatment services by your agency each year?
Five agencies reported making referrals for children/youth with a range of 1 to 200, for a total of 230 referrals.

Approximately how many transition aged youth (ages 18-24) are referred out for counseling/treatment services by your agency per year?
Five agencies reported making referrals for transition aged youth with a range of 5 to 25, for a total of 42 referrals.

7) Approximately how many adults (ages 25-64) are referred out for counseling/treatment services per year?
All nine agencies reported making referrals for adults with a range of 1 to 1200, for a total of 1297 referrals.

8) Approximately how many older adults (ages 65 and older) are referred out for counseling/treatment services per year?
Six agencies reported making referrals for older adults with a range of 1 to 250, for a total of 391 referrals.

Number of Agencies Making Referrals by Age Group

	Children/Youth	Transition Aged Youth	Adults (25-64)	Older Adults (65 and older)
# Agencies	5	4	9	6
Percent	55.6%	44.4%	100%	66.7%

All nine respondents referred adults for counseling/treatment services, followed by two-thirds which referred older adults. Still, more than half the respondents (55.6%) referred children/youth for counseling/treatment.

	Children/Youth	Transition Aged Youth	Adults (25-64)	Older Adults (65 and older)	
# Referrals	230	42	1297	391	*1960*
Percent	11.7%	2.1%	66.2%	19.9%	*100%*

Because a majority of the agencies surveyed serve adults, the referral load for counseling/treatment services by the nine respondent agencies predominately consists of adults (66.2%).

9) In your opinion, how well do you think these referrals work?

Works well: people don't have problems following through and getting service	2	20%
Don't know	2	20%
Sometimes works: people sometimes get the treatment/ counseling services they need	**6**	**60%**
Doesn't work: people don't succeed in getting into care	0	0%
Total respondents	*10*	*100%*

No agency reported that the referral system does not work. Six (60%) of the 10 respondents reported that people sometimes get the treatment/counseling services they need. However, only 2 agencies (20%) reported that the referral system works well and 2 other agencies (20%) do not know if the referrals work.

10) Is there someone in your organization who is responsible for providing referrals for emotional or mental health problems?

Yes: 10 52.6%
No: 9 47.4%

Total respondents: 19

A slight majority (52.6%) of the respondents have staff responsible for providing referrals for emotional or mental health problems. Eight of the 10 affirmative respondents provided the following information (open-ended answers) on staff responsible for providing referrals.

Staff Responsible for Providing Referrals

Type of Staff	*# Agencies*	*Percent*
Senior Peer Counselor and/or Health Promoters	2	25%
Intake Staff/Manager	2	25%
Licensed Clinical Social Worker or Medical Social Worker	1	12.5%
Administrative Assistant or Operations Manager	1	12.5%
Chinese Helpline	1	12.5%
Youth and Family Coordinator	1	12.5%
Total respondents	*8*	*100%*

Nine of the negative respondents provided the following open-ended answers:

- The person can change depending on who is in charge of the program that the person needing the services is part of.
- All legal staff provide referrals.
- We don't receive calls regarding emotional or mental health problems. We are not a direct service provider, although several of our member organizations do serve populations directly.
- Individual/position not specifically designated for function.

- No resource is allocated.
- We have no position in this responsibility.
- Not someone solely designated for referrals. Mostly program directors refer their clients
- No, there are only three of us on staff.
- All staff members with client contact are responsible for making referrals.

11) Are any of your staff members trained to recognize possible signs of emotional or mental health problems in the population you serve or work with?

Yes:	**11**	**57.9%**
No:	8	42.1%

Total respondents: 19

Of the 19 respondents, 57.9% of the agencies do have staff trained to recognize signs of emotional or mental problems in their client population.

12) Are any of your staff members familiar with where and how to make referrals to mental health service providers?

Yes:	**14**	**70%**
No:	6	30%

Total respondents: 20

Although not all agencies have staff that make referrals, more agencies have staff who are familiar with where and how to make referrals. Of the 20 respondents, 70% have staff with such awareness.

13) Would you hesitate to make referrals if you recognized that someone had a serious emotional or mental health problem?

Yes:	0	0%
No:	**14**	**70%**
Sometimes	6	30%

Total respondents: 20

None of the 20 respondents would hesitate to make referrals. Only 30% would hesitate sometimes while 70% would not hesitate.

14) Please indicate why you would hesitate to make referrals: (mark all that apply)

Reasons for hesitating to make referrals	*# Agencies*	*Percent*
Would be seen as interfering in a personal issue	2	33.3%
Mistrust of the mental health system	2	33.3%
Lack of services to meet language/cultural needs	**5**	**83.3%**
Stigma around mental health	2	33.3%
People don't want the services	**3**	**50%**
People not eligible for public mental health services	2	33.3%
People not able to pay for services	**3**	**50%**
Immigration concerns (fear of being seen as a public charge)	1	16.7%
Other: We are sometimes bound by attorney-client privilege	1	16.7%
Other: Wouldn't know how to suggest that a person go see mental health care provider if s/he didn't ask for the referral	1	16.7%
Other: May face the client's mistrust of the mental health system or desire not be interfered with (as opposed to our staff mistrusting or not wishing to interfere)	1	16.7%

Total respondents: 6

Of the six respondents that sometimes hesitate to refer, 83.3% cite lack of services to meet language/cultural needs as a reason, followed by lack of ability to pay (50%) and no desire to seek mental health services (50%).

Number of Agencies with Certain Number of Reasons to Hesitate in Making Referrals

# Reasons	*Quantity*	*Percent*
1	1	16.7%
2	**2**	**33.3%**
4	1	16.7%
6	1	16.7%
8	1	16.7%
Total respondents	*6*	*100%*

While only one of the six agencies gave one reason as to why they would sometimes hesitate to refer, two of the agencies (33.3%) cited two reasons each. Half of the agencies cited at least four reasons as to why they would sometimes hesitate to refer.

15) Does your agency receive information about mental health services in Alameda County?

Yes: 8 40%

No: 12 60%

Total respondents: 20
Of the 20 respondents, only eight agencies (40%) receive information on mental health services in Alameda County.

16) What type of materials do you receive? (mark all that apply)

Types of Materials Received	*# Agencies*	*Percent*
Information about services available	**8**	**100%**
Information about how to make referrals	2	25%
Information about how to recognize signs of mental illness	2	25%

Total respondents: 8
All agencies received information about services available. Only 2 agencies (25%) received materials about services available, how to make referrals, and how to recognize signs of mental illness.

17) Where do you receive materials from? (mark all that apply)

Sources of Materials Received	*# Agencies*	*Percent*
Asian Community Mental Health Services	**5**	**62.5%**
Asian Pacific Psychological Services	**4**	**50%**
Alameda County Behavioral Health Services	**5**	**62.5%**
Other: City of Fremont, Human Services Department	1	12.5%
Other: ACMHS website	1	12.5%

Total respondents: 8
At least half of respondents receive materials from three major Asian providers in Alameda County.

Number of Agencies Receiving a Certain Number of Materials on Mental Health Services in Alameda County

# Sources	*# Agencies*	*Percent*
1	2	25%
2	**4**	**50%**
3	2	25%
Total respondents	*8*	*100%*

Half (4) of the eight respondents receive materials from two sources. Three-quarters of the respondents receive materials from at least two sources.

18) How useful are the materials you receive?

Usefulness of Materials Received	*# Agencies*	*Percent*
Very useful	3	37.5%

Somewhat useful	**5**	**62.5%**
Not useful	0	0%
Total respondents	*8*	*100%*

None of the eight respondents considered the materials not useful. Five (62.5%) of the eight respondents cited the materials as somewhat useful.

19) Do you have any suggestions to improve the way that outreach and referral of people with serious emotional and mental health problems is conducted?

The following open-ended responses from 19 agencies are categorized by theme.

Bilingual Providers/Services

- To increase recruiting translators.
- Special guidance/referrals to bilingual mental health providers.

Outreach/Education/Literature/Media, including in multiple languages

- Through radio/newspaper/churches/schools.
- Giving seminar to parents during class hours on Saturday.
- Literature that we can post in our offices is helpful.
- Provide educational/introduction program or advertisement on Chinese/Asian community TV or newspaper. Provide bilingual lists or flyers in library to state and explain all available agencies and services available to public.
- Create a website with a listing of low-cost mental health care providers in the area, including their language capabilities. A website, unlike a printed publication, allows for changes to be made (e.g. when an agency changes its services because of lack of funding).
- We need materials in the Tongan language.

Relationship/Coordination/Education among Agencies

- Closer relationship between our agency and mental health agencies.
- I think there is a need for a more coordinated way of knowing where to refer, what languages are available. Also, where to go for a crisis.
- Outreach to more community base organizations where the general public interact with each other on a daily basis. Through the social/psychological model we can reach out to a broader audience.
- I would like to see Asian Health Services and Center for Elders independence work in a more collaborative realm in delivering health care services to the Asian community.
- Establishing formal programmatic partnerships with one or more mental health service providers.
- Coordinated services and case management. Mental health work group so that community-based organizations and service providers are aware of the services available in Alameda County
- More personal contact with staff; staff presentations.
- Training for our staff members would make them more likely to actually refer than printed materials alone.

- Free trainings to organizations like us in how to identify and refer folks who need the service is also good.

More Funds for Additional Locations/Services

- Provide more funds to Asian Health Services in Oakland to reopen its satellite office in tri-city, and Chinese American Mental Health Network and John George Psychiatric Hospital to expand their services.

Specific Issues/Populations

- Most often the mental health concerns are related to domestic violence coupled with immigration issues. We refer to Asian Women's Shelter, API Legal Outreach and ACMHS to cover all bases.

Studies

Better studies need to be done to understand the links between mental health with structural issues that can be addressed, i.e. access to affordable housing, jobs, etc

Attachment 2: Diversity and Growth of Asian Population in Alameda County

Population Groups - Alameda County, California	1990	2000 (Alone)	2000 (Inclusive)	% Change From 1990 (Alone)	% Change From 1990 (Inclusive)
Total Population	1,279,182	1,443,741	1,443,741	13%	13%
White (Non-Hispanic)	680,017	591,095	632,973	-13%	-7%
Black or African American	229,249	215,598	233,484	-6%	2%
American Indian and Alaska Native	8,894	9,146	23,177	3%	161%
Hispanic or Latino	181,805	249,185	273,910	37%	51%
Asian Total	184,559	295,218	326,949	60%	77%
Asian Indian	15,282	42,842	47,194	180%	209%
Bangladeshi	36	169	213	369%	492%
Cambodian	3,538	3,533	4,325	-0%	22%
Chinese, except Taiwanese	66,999	108,751	119,190	62%	78%
Taiwanese	1,586	3,255	3,947	105%	149%
Filipino	52,535	69,127	81,324	32%	55%
Hmong	10	180	184	1,700%	1,740%
Indonesian	545	784	1,300	44%	139%
Japanese	13,592	12,540	18,656	-8%	37%
Korean	9,537	14,217	15,949	49%	67%
Laotian	2,895	3,438	3,896	19%	35%
Malaysian	93	111	276	19%	197%
Pakistani	798	2,019	2,642	153%	231%
Sri Lankan	104	210	278	102%	167%
Thai	791	1,198	1,611	51%	104%
Vietnamese	13,374	23,817	26,365	78%	97%
Other Asian	2,844	9,027	-	217%	N/A
Native Hawaiian/ Pacific Islander Total	7,995	9,142	17,548	14%	119%
Native Hawaiian	2,810	1,467	4,718	-48%	68%
Samoan	1,143	1,508	2,189	32%	92%
Tongan	712	1,558	1,970	119%	177%
Guamanian or Chamorro	1,895	1,482	2,462	-22%	30%
Fijian	934	1,576	1,968	69%	111%
Other NHOPI	501	1,551	-	210%	N/A

Source: U.S. Census Data compiled by Asian Pacific Islander American Health Forum, www.apiahf.org

Attachment 3: Foreign Born and Naturalized Rate of Foreign Born for Asian and Pacific Islander Populations in Alameda County

Population Groups – Alameda County, California	Foreign Born	Naturalization Rate of Foreign Born
Total Population	27%	43%
White (Non-Hispanic)	8%	50%
Black or African American	4%	41%
American Indian and Alaska Native	11%	40%
Hispanic or Latino	43%	24%
Asian Total	63%	53%
Asian Indian	75%	33%
Cambodian	59%	51%
Chinese, except Taiwanese	64%	56%
Taiwanese	75%	50%
Filipino	60%	63%
Indonesian	63%	36%
Japanese	23%	29%
Korean	65%	52%
Laotian	62%	50%
Pakistani	77%	38%
Thai	63%	32%
Vietnamese	71%	61%
NHOPI Total	30%	39%
Native Hawaiian	2%	45%
Samoan	10%	56%
Tongan	45%	34%
Guamanian or Chamorro	5%	24%
Fijian	80%	29%

Source: U.S. Census Data compiled by Asian Pacific Islander American Health Forum, www.apiahf.org

Attachment 4: Poverty Rates Among API Subgroups in Alameda County

Population Groups - Alameda County, California	Below Federal Poverty Line	200 % of Federal Poverty Line	Public Assistance Income
Total Population	11%	24%	4%
White (Non-Hispanic)	6%	14%	2%
Black or African American	20%	39%	10%
Amer. Indian /Alaska Native	12%	29%	6%
Hispanic or Latino	14%	35%	5%
Asian Total	11%	23%	5%
Asian Indian	7%	16%	2%
Bangladeshi	N/A	N/A	N/A
Cambodian	43%	65%	34%
Chinese, except Taiwanese	12%	26%	5%
Taiwanese	16%	23%	1%
Filipino	5%	13%	3%
Hmong	N/A	N/A	N/A
Indonesian	10%	13%	3%
Japanese	9%	16%	1%
Korean	14%	27%	2%
Laotian	31%	52%	35%
Malaysian	N/A	N/A	N/A
Pakistani	13%	20%	2%
Sri Lankan	N/A	N/A	N/A
Thai	16%	26%	2%
Vietnamese	25%	43%	20%

Attachment 4: Cont'd.

Population Groups - Alameda County, California	Below Federal Poverty Line	200 % of Federal Poverty Line	Public Assistance Income
Native Hawaiian/ Pacific Islander Total	10%	32%	4%
Native Hawaiian	10%	25%	2%
Samoan	7%	45%	4%
Tongan	16%	50%	10%
Guamanian or Chamorro	7%	22%	1%
Fijian	8%	28%	5%

Source: U.S. Census Data compiled by Asian Pacific Islander American Health Forum, www.apiahf.org

Attachment 5:

Burmese Community Focus Group Summary
December 4, 2007

Experience of Trauma and Loss

- His father sent him to school. During that time there was fighting between armed groups and his parents were divorced. Since that time he did not see his parents or live with them. He feels very sorry that he cannot see his parents.
- 80% of refugees are uneducated. Most of them never dreamed of coming to the US because of their situation. Their villages were burned down and were victims of regimes. They were refugees for a very long time. Some are political activists and flee their country to avoid the government actions.
- Most of them live in miserable life in the camps with no futures. They came with hope for their future and their children's future.
- Those living in Thailand illegally may face trouble with police. In the US, they worry about the police because of their past experiences. They worry that the police with threaten them as they did in Thailand.

Parenting Issues

- Some are differences in parenting skills between countries. Children in the US are too open and not as disciplined. More discipline for children in their country and culture. One example, children can come and go to school on their own and do not need to be taken there as in the US.
- They don't know how to deal with fights with their children at school. They cannot speak to school teachers as they did in their country.
- Daughter had problems with English and does not do well at school. Daughter is 11 years old. Parents cannot help so they are frustrated.
- Son is 5 years old. He is fighting at school and she is called to school. In her country, the teacher is able to address the children's behavior. She understands that he was fighting but cannot understand the details. They don't have parenting skills, so they don't know how to manage her son's behavior. Her son does not understand the language so is not interested in school. She was very excited to hear about the services explained to them and is very interested in learning parenting skills

Teens and young adults in the community:

- Her 13 year old was in third grade in Thailand. In the US, he was placed in the ninth grade and is struggling in school. He goes to school and asks his parents for help. They don't know how to help them. In their country, the grades are based on ability not age.
- They are offered help after school, but they are afraid of what would happen if they are late. They are worried about their safety when it gets dark. They have difficulty with transportation.
- Her daughter goes to work to all day and does not have time to go to school. She is 19 years old and would like to continue her education.

- Her concern is that she is a mother of four. She thinks too much and strays into depression. She would like to know if there are medications that can help her.
- Once 18, they begin to work. They cannot continue their education because they can earn money to support the family. Young people tend to have very basic jobs.
- He does not know his ABC's but has to work full-time. He goes to work but cannot read the signs on his way. He does not have time to learn English. He heard in Thailand that in the US, they only have to go to school and the government will take care of everything.
- They don't know how to take advantage of the opportunities to get an education.
- He cannot get a driver's license because everything is written in English. Sometimes the job opportunities are far away. They know how to drive but can't get a license.
- She is living too far from school. They must leave for school at 7:30am but the teacher complains that they are late. How do we address this with the teacher? They cannot explain that they live far away and must walk 30 minutes to get to school. They do not take the bus because they have to wait and it is unreliable.

Accessing Services

- They don't know who to speak with at school to access help for their children. They receive calls from school and will go their but they do not understand the language.
- Some may not be qualified for services from our agencies and may suffer. They may have more significant needs later.
- Families have basic needs to survive: housing, jobs, and cooking skills.
- International Rescue Committee: helps with basic needs such as housing and house wares. When they have jobs, they can no longer receive help. The organization has limited resources and cannot help all the families in the communities.
- She has six family members but limited food stamps. It is not enough for family and they can only eat a little. They don't enough money because of the cost of rent. They regret coming to the US because of the problems they face. They are very unhappy.
- There is no one that speaks Burmese at the county agencies. They have other languages but no one speaking Burmese.
- They came from a camp to Georgia. They heard that when they come to the US, they will get services and help. When they came, they did not get any help at all. They were disappointed and move to Oakland. They don't have any assistance, no food stamps or assistance. Her mother is very depressed and wants to move back to Thailand.

Accessing Health Care

- For example, they got a bill for $400 for a visit to the doctor. They were shocked that they received such a bill for just visiting the office. They did not receive any medical treatment. She has very serious health problems. Her mother does not have strong legs. She fell in the bathroom and hurt her back. They will not go the hospital because they are afraid of the large bills for money.
- They need very basic information to know how to access medical services. They will not go to the hospital because they are afraid of the large bills.
- They are afraid to go even when they are qualified for Medi-Cal.

- They have many appointments at the hospital because of their three children. They have to be at the hospital all day because they are waiting for a translator. This adds more stress because it takes time away from work.
- It would be very helpful to know where they can go to receive better medical treatment and services.
- Even when ill, they are afraid to go the hospital because of the difficulty with language. They have difficulties making appointments and understanding the system.
- When in Thailand he did not have disease or any problems. Even with the technology here, she has not gotten the treatment she needs. They could not sleep because they were worried about her health. How can the agency help him with this? Since he got the news that she is sick, he cannot sleep and does not know what to do.

Community Spread Out/Difficult to Organize/Reach

- There are over 20,000 here. They come in different ways and live in different areas. Therefore, it is difficult for them to organize themselves. There are some efforts to organize. There are some churches in Oakland and Fremont, but they are spread out over the Bay Area.
- There are no systematic ways to access the Burmese community because they are spread out. We are just getting started in getting organized. It is difficult to reach them because they come from different refugee camps.

Is there interest in training people in the community?

- There are a few people who volunteer to help people in the community (like Anil).
- The Burmese community would appreciate a training, a one-day training to help them understand the system and meet their basic needs.
- When seeking help, they are told to ask their friends and colleagues, but they are very busy with their own lives.
- The community will respond to events but there is no systematic way of addressing their needs.
- Most have basic jobs that requires long working hours. So they don't have time to provide support to the community.
- They have little transportation so it takes 3 to 5 hours to reach their jobs. They don't have time to learn English or about the system.

Problems between couples:

- She has three kids and her husband has a very low paying job. They don't what to do with only one source of income. They get into arguments over small things. These become bigger problems. They feel depressed and cannot sleep. They don't have patience and argue more and more.

Older people in the community:

- Her mom is 74 years old and cannot walk very well. She sometimes goes to temple but she is very unhappy with her life.

Attachment 6:

Cambodian Families Focus Group Summary
August and September 2007

Behavioral health services received - Most parent have utilized mental health services from either ACMHS or APPS, including case management, family counseling at home at in the office. Their children have received psychotropic medications from Children's Hospital.

Hope to achieve from BHCS for your child - See their children going to school regularly, behave respectfully to adults, not run away from home, not getting into trouble with probation or legal system.

How entered services - Referred from court, EBAYC, case worker, Cambodian Development, Inc., their primary therapists or case manager. Difficult to find services for their children because they do not know the resources in the community. They usually go to non-profit agencies for help.

Satisfaction with services - The children's behavior is still the same and they do not make much progress from the services they receive. They feel better and supportive from the experience of talking with therapists and understanding their children's behaviors. They also appreciate the hard work from their children's primary therapists.

Suggested improvements - Very frustrated with their children's behaviors and would like to see them in residential treatment program, or probationary camping, group home or any safe contained environment where they do not have to worry about them ending up dead on the street. Asked to have services flexibility to their needs such as frequent home visits. Would like to have after school program, youth enter or a place where their children could go for home-work or doing social activities so that they would not be on the street. Would like to have their case managers or therapists work with those children in a safe settings. They also want more contact with their case managers and therapists.

Concerns - No. Trust the therapists and feel confident about their work.

Discussion with therapist about diagnosis and medication - Diagnoses - ADHD, intermittent explosive disorder, anger problems and taking psychotropic medications for anger. Children have behavioral problems that the teachers could not control and some sleep during school because of medications. Children's therapists explain the medications, their importance and treatment objectives. Worry about the medications and afraid their children may overdose.

Attachment 7:

Tongan Focus Group Summary
October 11, 2007

Accessing Services

- Not knowing where to start, how to access services
- Lack of resources (health, mental health)
- Disability, resources difficult to find, navigate (as compared to Utah), schools aren't able to connect to resources
- Number to Tongans don't have insurance, (60%) most are self-employed
- Language barrier-people are afraid to call doctor, helps to have Tongan Doctors
- Because many Tongans are immigrants most live together, making their income too high for medical
- Lack of financial resources including insurance

Community Factors

- Families suppressed talking about problems - culturally taboo, avoid problems to keep harmony

Where do they go for help?

- Problems are shared with Pastors

Children/Youth/Parenting Issues

- Children not finishing high school, get involved with drugs
- Lack of communication with parents
- Parents have no connection with school system (e.g. school site counselor) school activities, etc)
- Parent's expect schools to take care of their children
- Parents have no "Voice," dis-empowered as parents
- Parent needs to establish the priorities in the home, build strong foundation in the home
- Girls who committed suicide (3)
- Verbal abuse at home
- Issues with sexual orientation
- Survey with teens reveal that they don't know where to go for help
- Sexual abuse
- Often sign of something going on
- Appeal of joining gangs or getting involved in "criminal" activity
- Being profiled
- Community environments (being exposed to bullying)
- Parents involvement – After school programs, tutoring Polynesian dance to students
- Home Stressors:
  - Parents not knowing how to get help
  - Competing activities/priorities get in the way (e.g Church)

- Difference in disciplining practices that are allowed

18-24
- Transitional age youth, adults
- Young Parents
- Many in this age range are incarcerated, lost

What Parents can do:
- Parents willing to stop the cycles
- Parents communicate with their children
- Parenting classes (e.g learn different ways for disciplining) early warning signs
- Both parents agree to parenting practices
- Encourages Tongan culture (Tongan dance) break down barriers between parent and their children, story telling
- Knowing the legal system(rights)
- Vote
- Parents don't know the kinds of drugs their children are using
- Encourage Tongan community to take advantage of resources such as English classes

Current ways of finding info/ Access to community
- Word of Mouth
- Through local churches (faith community)
- Community newsletters

Resources aware of:
- New connections (drug rehab)
- Native American clinic (Interpreter) mammogram for women
- APAYL (Learn skills, work in the community...)
- Boy's Scouts

Employment
- Apprenticeships

Attachment 8:

Asian Community Mental Health Services
&
Asian Pacific Psychological Services
Community Feedback Meeting
Tuesday, December 19, 2007

Present: John Fong, Beatrice Lee, Terry Bautista, Nhi Chau, Dong Suh, Ann Rhee Menzie, Lillian Galedo, Jen Lee, Brian Tang, consultant Laurin Mayeno
Recorder: Melissa Moy

Filipinos for Affirmative Action - Oakland and Union City youth program. We don't have in-depth youth counseling. Inconsistent provider – in and out counselors other agencies provide (ACMHS is a provider) Would like to see a consistent "professional counselor integrated in their existing programs. Would also like to see youth/counseling services expanded to Alameda, Hayward. Would like to see materials development and peer counseling/peer mediation. Brian mentioned that they have those programs in some schools.

Oakland Unified School District - We are looking forward to having mentors at Lincoln. If the process goes through, there will be professional or paraprofessionals working on site. Lincoln is the mecca where kids congregate after school. Strategically placing professionals at places like Lincoln would be great not just for community but for the kids in general. These are the kids that don't come to school, and I won't get to meet them. Would like to see one stop shop as much as possible (reproductive health, counseling, tutoring) but where not possible then a much better cross-agency referral process.

Asian Health Services - has Social Worker integrated in their primary care for adults. Because of stigma, patients who come to clinics and exhibit psychosomatic symptoms should be treated by mental health services agency, but are not getting help. Need is greater than what one Social Worker can handle. Would like to see similar integration in their youth clinic. When we started our teen clinics on Wednesdays, one of the key needs we saw was mental health services for youth. One thing we learned – we are catching a lot of youth that are not in the school system. Would also like to see general education. AHS currently has adult leadership in 5 languages. So structure is in place for education to happen.
What works in the youth clinic: Same staff that works with youth also works clinical. Continuum of service has built rapport for the children.

Pilot program: sexual exploitation of young woman, ages 12 to 19 mostly. One strategy also in pilot: intergenerational program. Cooking program brings volunteer moms to come in to teach daughters and peers Southeast Asian foods of their choice. Moms given a small stipend. Also has a court advocacy component. Huge need for

combination. Continuum of service and who they build relationships with. To have as few referrals as possible… If there's a way to examine the referral process and the linkages to support programs. How do we know better what programs are in schools? Helps providers to be more fluid when aware of programs. Needing to have as much one-stop services as much as possible. Wish list: Social worker case manager who would be integrated into existing programs. Build relationships and trust with youth. Also the person would be a catch-all.

Community Strengths data:
- Cultural Identity and Reconnection to Culture
- Sense of peer networking

Korean Community Center of the East Bay - Only Korean community services org. in East Bay. It is the catch-all and clearinghouse organization. *Have domestic violence program – lot of mental health and emotional issues come up. Access – Hard don't have enough Korean-speaking professionals *Program for youth has been held for now. Previously had it. Concerned underserved Korean speakers. Korean community still stigmatized mentally ill people. They themselves and family are very shy and getting help. Would like to see a staff person who can organize community education and outreach through the following venues: faith Community, youth leadership program, and media
This model has proved effective through their Domestic Violence program because youth in the program and members of churches they work with speak much more openly about DV then general Korean population. Would like a professional person they can refer adults and kids to/ a person to do outreach and advocacy to reach faith-based groups and media

Community Strengths - Families have strong family ties and are very protective. If we call parents to do social issues workshops, they won't come, but if we do parenting classes, they will come

Oakland Asian Students - Would like to see integrating outreach/education/MH services with academic programs. Because not only is there no stigma with academics, but parents are actually enthusiastic. There is a movement going to have the one-stop services to be all school based. See both benefits and minuses (schools have much broader reach any other providers, but there are also a lot of kids who do not want to be in schools. Outreach should include club sponsors. Would also like to see professionally development of existing agency staff (in MH and in cross cultural training among agencies.

Other Discussion:
Focus Resources - ACMHS previously had each school-based staff at multiple schools, and it did not create much presence. Now focusing most staff at one school. Plus: Effective presence. Minus: Not reaching other schools

- Adapt therapy model in church settings

- Get faith members to volunteer
- Effective collaboration (seek volunteer, non-paid help) would make program feel consistent
- Getting retired professionals and retirees to help

Values - Take advantage Close-knit family structures. Host a community fair – Focus on academic success

Outreach & Advocacy
- Under use of ethnic media
- We like the Kaiser ads
- Ask media to collaborate on campaigns
  Train community leaders. Make contact with local chambers of commerce and civic groups

How do we improve communication with schools – knowing available resources and programs?
We need to be more organized; requires good leadership

Wish list
Social worker/case manager who integrates programs, referrals. One-stop services – continuity of care for youth
- Professional who can refer adults and children
- One person who does outreach into community and advocacy (For Korean population – ethnic media and faith-based groups are great resources for spreading information)
- Education and Tutoring Services
- Family liaison – promotes awareness of programs

Southern Alameda County (or anything outside of Oakland) is somewhat neglected - Little structure, resources. Union City residents won't travel to Oakland for services. Poverty level qualifications disqualify a lot of working poor who could use mental health services. Many in Fremont need services but these working poor are not poor enough.

Strategies/Services - 1-to-1 services have limited impact on large population - Media campaign should be a multi-agency collaboration. One campaign in many languages

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[i] Mental Health Service Act, Asians & Pacific Islanders: Executive Summary of the Asian & Pacific Islander Consumer & Caregiver Survey, Asian Community Mental Health Services, June, 2005

[ii] Ponce, N. et al, Advancing Universal Health Insurance Coverage in Alameda County: Results of the County of Alameda Uninsured Survey, UCLA Center for Health Policy Research and Community Voices Project, 2001.

[iii] Lavarreda, S.A., Brown, E.R., Ponce, N. Insurance Rates of Asian American and Pacific Islander Children Vary Widely, UCLA Health Policy Fact Sheet, UCLA Center for Health Policy Research, June, 2005. www.healthpolicy.ucla.edu.

Mental Health Services Act
Prevention & Early Intervention

COMMUNITY REPORT EXECUTIVE SUMMARY COVERSHEET

Instructions:

1. Please use this form as a cover to any report you want to submit for review by the PEI Planning Panels.
2. Email this completed form and an electronic version of your report (Word document or PDF) to mhsa@acbhcs.org no later than December 14, 2007.

Organization: Casa del Sol, La Clínica de La Raza
Contact Person: Heather Barnett, LCSW
Address: 1501 Fruitvale Avenue, Oakland, CA 94601
Phone No. (510) 535-6200
Email address: Hbarnett@laclinica.org

**Please attach a list of all groups and organizations that contributed to this report.*

Diabetes Management Group at La Clinica Preventive Medicine Department
Seniors Activity Group at the Unity Council
Parenting Gropu at the Family Council
Promatoras Group (Women Community Health Edcuators) at Casa CHE
Men's Support Group at Casa CHE
Alzheimer's Caretakers Supprot Group at Posada de Colores (Seniors Resnidence)
Adolescents Group (Orgnaized by Casa del Sol and Clinica Alta Vista – Adolescent Health Clinic)
Spanish Speaking Disabled Adults Group from CIL (Center for Independent Living)

What age group does your organization serve or represent?

☒ Children & Youth (0-18) ☒ Transition Age Youth (14-25) ☒ Adults (18-59) ☒ Older Adults (60+)

Under each category, choose the item your report PRIMARILY addresses:

Key Community Mental Health Needs

☒ Disparities in Access to Mental Health Services
☒ Psycho-Social Impact of Trauma
☒ At-Risk Children, Youth and Young Adult Populations
☒ Stigma and Discrimination
☐ Suicide Risk

Priority Populations

☒ Underserved Cultural Populations
☐ Individuals Experiencing Onset of Serious Psychiatric Illness
☒ Children/Youth in Stressed Families
☒ Trauma-Exposed
☐ Children/Youth at Risk for School Failure
☐ Children and Youth at Risk of Juvenile Justice Involvement

Community Report Executive Summary
Focus Groups with Latinos in Northern Alameda County

Section I- Organizational Background

Founded in 1971, La Clínica de la Raza, Inc. (La Clínica) is a non-profit Community Health Center with a mental health department in Alameda County called *Casa del Sol*. *Casa del Sol* was founded in 1973 and now provides counseling and psychiatric services to approximately 1,200 individuals/families per year across the lifespan. *Casa del Sol* specializes and focuses in treating individuals and families who require linguistic (Spanish) or cultural (Latino) specialty services. The following services are provided at *Casa del Sol*: screening, information and referral as a satellite of the ACCESS program, crisis stabilization/brief treatment services for adults/older adults in crisis, comprehensive services for adults/older adults with severe mental illness, comprehensive mental health services for youth including the treatment of the 0-5 population, children, youth, adolescents, transitional age youth/adults. Additionally, *Casa del Sol* has specialty programs that focus on child abuse treatment and prevention, domestic violence treatment and prevention, and mental health services for those who with HIV+/AIDS.

Section II- Data Sources

Casa del Sol staff assisted the project coordinator in identifying already existing community groups in which to conduct the focus groups. Trained clinical, bilingual staff conducted each focus group- encouraging conversations among participants and honest feedback about difficult topics. Focus group questions were developed from questions already being used throughout Alameda County for similar groups.

Questions (asked in Spanish and written below in English) are as follows:

1) What does trauma mean to you and your community? What are the different types of trauma that affect you and your community the most?
2) What are the main mental health issues/emotional problems you deal with personally and in your community? How do you know someone in your family is experiencing mental health problems? Which of these issues need the most attention/services?
3) What types of services do you think would be helpful to prevent and treat the above problems? Here are some examples: groups, practical assistance, individual services, family services, educational classes, drop-in assistance, health fairs, advertising?
4) Where and by whom would you recommend that prevention or treatment services be provided? Here are some examples: Counselors, teachers, other community members/peers, clergy.
5) What prevents people from seeking and receiving services?
6) What are some ways that we can best tell people about the services that exist or might be available in the future?

Methodology:

Eight focus groups were conducted with a total of 115 participants. *Casa del Sol* contacted existing community groups, listed below, and utilized the above questions to conduct focus groups as the data source for the PEI

1) Diabetes Management Group at La Clínica Preventative Medicine Department
2) Seniors Activity Group at the Fruitvale Unity Council
3) Parenting Group at the Family Council
4) Promotoras (Health Educators) Meeting at Casa CHE (Community Health Education)

5) Men's Support Group Meeting at Casa CHE
6) Alzheimer's Caretakers Support Group at Posada de Colores (Seniors Residence)
7) Adolescent Group from Casa del Sol and Clínica Alta Vista
8) Spanish Speaking Disabled Adults Group from the Center for Independent Living

When identifying the groups, care was taken to include both consumers and family members of consumers. Participants in the focus groups were primarily Spanish speaking members of the Latino community and included: parents, family members, adult and adolescent consumers, homebound older adults, victims and perpetrators of domestic violence, and health educators.

Section III- Recommendations

With a strong focus on the MHSA PEI Planning Guidelines of 1) community collaboration and 2) involvement of unserved/underserved populations, *Casa del Sol* endeavored to gather information from the Latino community in East Oakland (Northern Alameda County) regarding perceptions of mental illness, service needs and possible service models. The focus groups were extremely rich with information and opinions, as many participants and their families had stories to tell regarding their experiences with the mental health system and their unmet needs. A very important and salient issue emerged from the findings is that the community desperately needs more information, education and resources, most specifically for those who may not have traditionally qualified for specialty mental health services. For more detailed information as to the results of the focus groups, please see the attached report.

The Service model that we are recommending is a "**Community Based Consultation Model**" that is driven by a **Strengths Based Cultural Perspective**. Many focus group participants stressed the importance of providing services in the communities and locations where people live, shop, and receive other services. Both community group leaders as well as the community members noted the importance of Expertise in the following areas: (1) knowledge of mental health issues in the Latino community, (2) knowledge of how to help individuals who need immediate assistance, and (3) knowledge on how to help people access services and resources. Each of the focus groups indicated the importance of having people who are from the community, are bilingual and bicultural to provide the services. Additionally each group recommended that information, education, services and resources be provided to Latinos who are already involved with organizations or programs such as senior centers, medical clinics, housing facilities, after school programs, head start programs, schools, churches, senior residence/recreational programs, multi-service centers, etc.

Based on the needs expressed by both community members and community group leaders, we recommend a **bi-directional "Community Based Consultation Model**." First, we recommend that consultation be available to leaders who are already working with the community. This model would create a far reaching effect as these leaders--teachers, church leaders, disability advocates, and support group leaders--will reach many more community members in the future by building upon their [leadership] capacity to inform, educate, screen and refer their community members regarding mental health issues. Secondly, the Consultants would be available to go into the community to provide not only group services, but also individual and follow-up services directly via/through existing community groups. Thus the "Community Based Consultation Model" would utilize the infrastructure already in place in the community and provide screening, education, services, and resources to individuals and families where they are already attending. As the community has made this request we highly recommend every effort be made to meet this request as it offers the opportunity to reach many people with minimal infrastructure costs.

We recommend that **teaming up of a mental health professional and a *Promotor(a)*** would make an ideal combination of skills to effectively and efficiently provide the "Community Based Consultation Model." While the Latino community often looks towards doctors and psychologists for expertise in mental health issues, the community is also familiar with the use of *Promotoras* as community health workers. Hiring and training Consumers and Family Members as *Promotoras* would help address the issue of stigma which was so often reported. *Promotoras* would provide a unique share their experiences and model recovery.

In practice, the Consultants (Mental Health Professional and Promotora (Consumer or Family Member of a Consumer) would provide information and education to existing community groups on a periodic basis, be available to provide individual consultation follow-up to individuals in the community as well as in the groups as needed, and meet with community group leaders to provide information and education on screening, supporting, referring and providing resources to the group members. One important issue to note is that many community members who are need and seeking early intervention services do not currently qualify for services. This model will be most effective if treatment and psycho-education groups were made available to which people can be referred, i.e, for depression, anxiety ("nervios"), grief, and trauma. We recommend these resources be developed and provided by the Consultants within this model so that people who are identified as needing services can be referred for early intervention services that will prevent them from deteriorating and requiring higher levels of care.

The model being presented identifies and addresses the local community mental health needs related to:
1) Disparities in access to mental health services
The Community Consultation model will begin to address Alameda County's significant disparity in access to mental health services for Latinos as the model offers services in a culturally competent model by a mental health professional and a trained *Promotora* (Peer Counselor) working with a trusted community organization. Although this model provides prevention and early intervention services, there will continue to be a need for treatment services for those identified as needing treatment but who do not currently quality for ACBHCS services. Access will improve when services are more available and more open to those in need, at the time when they are in need. Many focus group participants discussed not being aware of services and not having severe enough problems to get services before their problem became more severe. This model creates a culturally sensitive bridge to mental health services as well as providing early intervention services when needed, in the community.

2) Stigma and Discrimination
The Consultation model operates from a strength-based, culturally-focused perspective. The model acknowledges the stigma that exists in the Latino community around accessing mental health services. It recognizes /addresses the history of discrimination that Latinos have experienced as they have fled their countries of origin and arrived in a new country where they face issues of loss of family, culture and language barriers. The model hopes to reduce stigma by providing services in a group setting, creating a family environment of "education" not diagnosing, labeling, categorizing community members as "ill" or "crazy", as they have felt in the past. Additionally the recommended Consultant team will include a Promotora (Peer Counselor) who can speak to his/her personal experience of mental illness, and model recovery to the community.

The model being presented identifies and serves priority population, including:
1) Underserved cultural population
ACBHCS's data shows that the Latino population is currently served at one-third the rate of the Caucasian population and one-third the rate of the African American Population in Alameda County.

The **"Community Based Consultation Model**" being recommended would be a culturally based and Latino focused program aimed at reaching unserved Latinos. Programs that focus on the Latino population generally are more successful in reaching Latinos than programs that aim to serve a broad range of ethnic/linguistic populations all at once.

2) Individuals experiencing the onset of serious psychiatric illness
Focus group participants regularly mentioned the lack of information and support as they witnessed their family members experiencing the onset of serious psychiatric illness. By providing more information and consultation by a trained bilingual, bicultural mental health professional it is more likely that families will have support and access to services earlier into the onset of illness. Again, by reducing shame and stigma in reaching out for support, families will hopefully feel safer asking questions and accessing available resources, preventing unnecessary hospitalizations and harm to self/others.

3) Children and Youth in Stressed Families
By nature of the communities in which many Latinos live in Oakland, there are many daily stressors, including community violence, economic problems and lack of work. In addition, many families struggle with abuse, domestic violence, trauma and loss of family, culture and homeland. It is our hope that the Consultation Model will address the many needs of children and youth in stressed families, given that services will be provided in the community, particularly at schools and parenting groups,. By providing not only information about access to mental health services but food, housing and safety resources, this model will meet community needs on multiple levels.

The model being recommended works towards achieving desired outcomes, including:
1) Community Collaboration
The heart of the Consultation Model is working with existing community organizations. Many of our organizations are at capacity in terms of providing services, are not aware of how to navigate the challenging mental health system and do not have training in screening for mental health concerns. The Consultation Model will provide needed support, information and education to community organizations. The Consultation Model will be successful by building connections and bridges to places where the community already has alliances and trust. Through creating networks to gatekeepers and natural leaders in schools, churches and community organizations, services will be more accessible and available to more people.

2) Cultural Competence
The Consultation Model insures cultural competence by building on working alliances with community organizations and a strong connection to the Latino community. Bilingual, bicultural staff is essential, as are peer-level providers who live in and have received services from the community.

3) Individual/Family Driven Programs and Interventions with attention to underserved communities
As described above the Consultation team that is being recommended includes pairing a mental health professional with a Promotora (Peer Counselor). Promotoras will have the life experience of either being a consumer or being the family member of a consumer. The interventions provided under the Consultation Model are derived from the expressed needs of members of the Latino community.

4) Wellness Focus
Through the use of natural community leaders and peer/consumer "Promotoras" as providers of services, the Consultation Model truly integrates and believes in the concepts of Wellness, Recovery, and

Resiliency. The use of a cultural/strength-based model of consultation is based in the belief that “La Cultura Cura” --a wellness belief about culture being curative.

5) Integrated service experience

The Consultation Model works to integrate services in a number of different settings, including head start programs, schools, after school programs, churches, senior centers, etc. In an effort to provide services where people live, work, shop, and go to school, the model integrates mental health consultation and information/education with other services people receive, including tutoring, English as a Second Language programs, support services, and recreational activities.

Mental Health Services Act- Prevention and Early Intervention Initiative
Community Input and Feedback from the Latino Community in North Alameda County
October-December 2007

Introduction

As part of the Mental Health Services Act (MHSA) Prevention and Early Intervention Initiative (PEI), La Clínica de la Raza's *Casa del Sol*, was offered the opportunity to collect feedback and information from the Latino Community in North Alameda County. The method selected was to conduct focus groups with already existing community groups. It is our hope that the opinions, values and conversations of the participants will be helpful in informing MHSA Planning Panels, Workgroups and MHSA Oversight Committees in creating and transforming services provided to Latinos in Alameda County.

Methodology

Casa del Sol staff assisted the Focus Group Project Coordinator (Heather Barnett, LCSW) in identifying community groups in which to conduct focus groups that focused on prevention and early intervention. Trained clinical bilingual staff and Peer Counselors conducted each focus group- encouraging conversations among participants and honest feedback about difficult topics. Focus group questions were developed from questions already being used throughout Alameda County for similar groups.

Questions (asked in Spanish and written below in English) are as follows:

1) What does trauma mean to you and your community? What are the different types of trauma that affect you and your community the most?
2) What are the main mental health issues/emotional problems you deal with personally and in your community? How do you know someone in your family is experiencing mental health problems? Which of these issues need the most attention/services?
3) What types of services do you think would be helpful to prevent and treat the above problems? Here are some examples: groups, practical assistance, individual services, family services, educational classes, drop-in assistance, health fairs, advertising
4) Where and by whom would you recommend that prevention or treatment services be provided? Here are some examples: Counselors, teachers, other community members/peers, clergy
5) What prevents people from seeking and receiving services?
6) What are some ways that we can best tell people about the services that exist or might be available in the future?

Methodology:

Eight focus groups were conducted with a total of 115 participants. The following groups were interviewed

1) Diabetes Management Group at La Clínica Preventative Medicine Department
2) Seniors Activity Group at the Fruitvale Unity Council
3) Parenting Group at the Family Council
4) Promotoras (Women Health Educators) Meeting at Casa CHE (Community Health Education)
5) Men's Support Group Meeting at Casa CHE
6) Alzheimer's Caretakers Support Group at Posada de Colores (Seniors Residence)
7) Adolescent Group organizad by Casa del Sol and Clínica Alta Vista
8) Spanish Speaking Disabled Adults Group from the Center for Independent Living

When identifying the groups, care was taken to include both consumers and family members of consumers. Participants in the focus groups were primarily Spanish speaking members of the Latino community and included: parents, family members, adult and adolescent consumers, homebound older adults, families facing issues of domestic violence and health educators.

The information presented below is organized based on the focus group questions noted above. Both general themes and quotes will be provided to summarize and present information gathered.

Information Gathered/Findings

I. Trauma/Community Problems

General Findings

The most common and frequent answer to the question related to trauma in the Latino community problems was: violence in the community and in the home, including theft, assault and gang related activity. Participants shared experiences of feeling unprotected and vulnerable in the streets as well as lack of involvement and protection from the police. There was a common theme in most groups about feeling fearful and mistrusting of the system that is supposed to help and support community safety. In addition, many participants mentioned economic problems and unemployment as significant causes of stress and depression.

- Fear of community violence (theft, assault), delinquency, gangs, drugs, homicide
  "*Problemas que pasan en la calle nos afectan en la casa… se vive una tension de tristeza, impotencia y coraje*" (Problems that happen in the street affect us at home… we live with a tension of sadness, powerlessness and anger).
- Fear of the police, fearful and mistrusting of "the system", immigration authorities and lack of protection and involvement from the police
  "*No sentimos seguros*" (We don't feel secure).
- Coming to the United States, the immigration process, adapting to a new language and new culture, and experiences of discrimination.
  "*Trauma por el simple hecho de ser indocumentado y escuchar que la imigración los asecha. Inclusive el miedo de ser deportado en su trabajo de uno*" (Trauma for the simple fact of being undocumented and hearing that the immigration is persecuting them. The fear of being deported while one is at work).
- Domestic violence/child abuse
- Economic situation, unemployment as a significant cause of stress and depression (if you want to add this here)
- Lack of health insurance
- Domestic violence and child abuse
- Low self-esteem
  "Como mujeres *somos más propensas- nos critican y nos produce un bajo autoestima*" (As women we are more prone- they criticize us and that produces low self-esteem)
- Sexual Abuse/Rape
- Physical Disability
- Alcohol and Drugs/Addiction
- Labeling children in school

- Dramatic, catastrophic news especially on Latino channels

II. Mental Health/Emotional Problems

General Findings

Depression was by far the first and most frequently noted emotional problems experienced by individuals and families. Participants discussed not recognizing symptoms, not wanting to admit they have sadness/ depression due to shame/stigma. Participants also mentioned their struggles with family members with severe mental illness, trauma and stress.

- **Depression**-- was by far the first and most frequently noted emotional problems experienced by individuals and families. (if you want to keep this sentence).

  "*No admitimos que lo tenemos o no sabemos que lo estamos sintiendo es depression, por que no tenemos la información de los síntomas sobre lo que es la depresión*" (We don't admit or don't know that what we have is depression because we don't have the information on the symptoms of depression).

  "*Yo me di cuenta hasta despues de un año que estaba deprimido no admitimos que nos sentimos deprimidos por la cuestion de machismo en nuestra comunidad, lo tenemos pero justificamos que estamos simplemente tristes, no sabemos que es lo que estamos sintiendo creo que nos hace falta educarnos sobre la depresión*" (I didn't recognize it until I was depressed for a year. We don't admit that we feel depressed due to 'machismo' in our community. We have it (depression) but we justify that we are just sad. We don't know what we are feeling, we are lacking education about depression).

  "*Uno esta sufriendo, se* deprime *y como no saca esto… los niños tambien estan sufriendo y es una trauma para ellos*" (One suffers, gets depressed and we never talk about it... children also are suffering and it is a trauma for them).

- **Mental Illness**

  "*Mi madre lo vivió, el papa de mi mama perdió la razón, mi mama pensaba que fue a causa de los corajes que hacia y ahora mi hermana también esta igual y esta completamente mal… no sabe de ella, esta como una bebe*" (My mother lived it, my mother's father lost his sense of reason. My mother thought it was because of his anger fits, but now my sister is the same, she does not know who she is, she is like a baby).

  "*Yo pienso que ignoramos la gravedad de la salud mental. Por ejemplo mi hermano se puso muy mal de los nervios y resultó que tiene esquizofrenia. Entonces cuando uno no tiene información sobre los síntomas, acude servicios equivocados que no son médicos*" (I think that we ignore the importance of mental health. For example my brother became very sick from his nerves and it turned out to be Schizophrenia. Therefore, when we do not have information about symptoms, we seek improper services that aren't medical).

- **Trauma**

  "*Me mataron una hija y luego enseguida se fue mi mujer y me quede solo. Yo me la pasaba en la casa, no sabía que hacer. Cúando llega la soledad en la noche, es cuando*

se siente la tristeza, y pues es un desafió a la vida, uno no sabe por que vivir... es un trauma." (They killed my daughter and then my wife left me. I spent lots of time in my house. When night comes the sadness kicks in and it's a challenge to live, one does not know what to live for… it's a trauma).

- **Stress**

  "El estrés por los niños y el no saber si la manera que uno los esta criando es la manera correcta." (Stress caused by children and not knowing if one is raising them the right way).

  "Se que muchos familiares cuidan a otras personas… a un familiar enfermo… y esto causa mucho estrés" (I know that many families care for other people… a family member who is sick…. and this causes a lot of stress).

- **Grief**
- **Anxiety**
- **Hypervigilance**
- **Isolation**
- **Anger**
- **Addictions**

III. What services are needed to prevent and treat traumas and emotional problems?

General Findings
Participants continued to recommend group services, both for support and for education, in order to prevent and treat emotional problems. Many focus group participants mentioned wanting a counselor to come regularly to their groups and provide support, information, resources. Participants suggested individual and family services as well, with a strong focus on making services accessible, including language and cultural competency, flexible hours, less restrictions on insurance, less expensive, closer to home.

- Group services- both support and information/education regarding mental illness, prevention and treatment for emotional problems as well as access to services

  "*Tuve una depression muy fuerte, tuve primero que aceptar mi depresión y después asistir a un grupo de apoyo me ayudó mucho*" (I suffered from a very strong depression, first I had to accept my depression, and later I attended a support group that helped me a lot).

  "*Ayuda en grupo es mas eficiente porque compartes experiencias"* (Help from a group is more efficient because you share your experiences).

"*Talleres donde den mas información sobre temas especificos, por ejemplo, auto estima, defensa propia, etc*" (Workshops where more information is given on specific topics, such as self esteem, self defense, etc.).

"*Mas información de como educar a los niños y para reconocer síntomas de abuso*." (More information about how to educate children and how to recognize the symptoms of abuse).

- Individual services (Adult, Children, Couples)
  "*Ayuda individual tambien es importante por ahi cosas mas personales que no sientan comodas en compartir en grupo*" (Individual help is also important because there are personal things that one doesn't feel comfortable sharing in a group).

- Crisis Services at the time when the person needs it
  "*Que hubiera una persona y pudiera ayudar en el instante que alguien necisite ayuda... para cuando uno este listo, que este alguien allí*" (For someone to be able to help at that moment that someone needs help. So that when one is ready, there is someone there).

- Low cost mental health services with less qualifications (both individual and group therapy)
  "*Yo necesitaba recibir terapia pero los co-payments eran demasiados elevados. Necesitan reconocer que nuestra comunidad es de bajos ingresos*." (I needed therapy but the co-payments were too high. You need to recognize that our community is low income).

- Services that are available with more flexible hours, so fathers can come after work

- Services and information in people's languages and their culture, in their communities

- Conferences for information and support
  "*Organizar conferencias en lugares grandes y proveer información. Organizar reuniónes en centros comunitarias*" (Organize conferences in big venues and provide information. Organize reunions in community centers).

- Services specifically for elders

- Services specifically for teens
  "Support groups for teens by teens, I don't like it when adults tell me what to do. I want to be able to invite my friends and not have the group be closed to only clients."

IV. Where should services be provided?

General Findings
Participants overwhelmingly supported services provided in already existing groups, community centers, agencies. There was strong support for services provided on the street, in homes and in churches--- or better said, "Its necessary to go where the people are" (Es necessario ir a donde esta la gente).

- In existing groups like in the Senior Center, Diabetes Classes, Alcoholics Anonymous or in the Casa CHE Men's Group
- On the streets in family homes through family members, friends
  "*Es necessario ir a donde esta la gente*" (Its important to go where the people are).
- Schools
- Churches
  "*Dios es lo mas importante… y estar en oración. Pero Dios tiene muchas cosas que hacer. Dios no le puede ayudar a uno si no le ayuda a si mismo*" (God is the most important… and to be in prayer. But God has a lot of things to do. God cannot help you unless you help yourself).
- Community Centers (Family Center)
- Medical Clinics
- Jails
- La Clínica de la Raza
- Crisis Hotlines
- Internet

V. By whom should services be provided?

General Findings
Many participants were very clear that services should be provided by already existing community leaders who understand their needs and situation. Participants recommended that service should be provided by people living in the community who were trained and could provide education and help connect people to necessary services. Again, participants returned to the necessity of providing culturally competent and linguistically appropriate services.

- Existing Community leaders who understand their needs and situation
  "*Es importante que los servicios estan proveados por los líderes de nuestra comunidad que vienen de Oakland y entienden nuestra situación*" (It is important that services be provided by the leaders of our community that come from Oakland and understand our situation).
- Promotoras (Community Health Educators/Trained Community Members) who connect people to necessary services (if you want to add in this from above).
- Teen Leaders
- Counselors (therapists and psychologists)
- Teachers
- Doctors

VI. What prevents people from receiving services?

General Findings
The most common and frequent response to the question of access was lack of information and confusion about existing services as well as symptoms and signs of mental illness and emotional problems. Participants talked about being sent to numerous different places and not knowing services existed for quite some time when they were much needed. Problems related to cost of

services, being turned away due to not having the right qualifications and language were common impediments to participants or their families receiving services. Stigma and shame were also mentioned as reasons one would not look for help.

- Lack of Knowledge and Confusion about existing services as well as symptoms and signs of mental illness and emotional problems.

  "*No saber con exactitud los servicios que se ofrecen*" (Not knowing exactly what services are offered).

  "*A veces la confusion, porque uno va pedir información y te envian a un lado, de ahí te envian a otro lado, y asi hasta que la gente se cansa y deja de pedir ayuda y necesita*" (Sometimes there is confusion. One goes to ask for information in one place, from there they send you to another place, and after that people get tired and stop looking for the help that they need).
- Being turned away due to not having the right qualifications and [English]language were common impediments

  "*Yo fui con mi hija a buscar un psicólogo. A veces uno va con toda ilusión que nos van ayudar pero cuando se trató de las aseguranzas no califique. Mi aseguranza tiene psicólogos pero solo hablan ingles y pues yo no hablo ingles, entonces me quede igual. Es muy importante buscar servicios en nuestra comunidad y en nuestro idioma*" (I went with my daughter to see a psychologist. Sometimes one goes with the illusion that they will help us but when it came to the insurance, I did not qualify. My insurance has psychologists, but they only speak English and I do not speak English so I did not receive any help. It is very important to seek services in our community and in our language).

- Stigma related to mental illness/Embarrassment/Shame

  "(no buscan servicios por) Verguenza de publicar tus intimidades con un terapeuta. Mas aparte son cosas que no se debe hablar con nadie. Se quede como secreto" (they don't seek services due to embarrassment to publicize your intimate information with a therapist. Apart from this, there are things that you shouldn't talk about with anyone. It stays like a secret).

  "*A veces no se habla con nadie para no dañar a otras personas y el sentimiento de culpa*" (Sometimes we don't talk with anyone so as not to hurt other people… and the feeling of blame).

  "*Pensamos que recibir terapia es solo para locos*" (We think that receiving therapy is only for crazy people).

- Fear related to being undocumented/immigration status

  "*Gente tiene miedo por no tener papeles, por eso no buscan servicios*" (People are scared because they don't have papers, because of this, they do not look for services).

- Fear about confidentiality

  "Te *afecta en algo? Esta en tu record? Si llega la policia y ve tu record va a pensar que estas mal*" (Does it affect you in anyway (seeking service)? Will it be in your permanent record? If the police come will they think you are "bad" (mentally ill)).

- Services too expensive
- Not having a severe enough problems to qualify for services
- Transportation, services are not available in one's neighborhood

- Difficult to qualify due to restrictions with insurance
- Lack of child care
- Hours of service are not flexible, particularly for men who are working

VII. What are the best ways to tell the community about the services that exist or may be available in the future?

General Findings
Although television and radio were consistently mentioned as ways to inform and educate the community regarding services, many participants mentioned the importance of "word of mouth" in the Latino community. Participants suggested that when one hears information from someone they trust, a health worker, their cousin, their clergy, they are more likely to trust and follow up with information. Information provided in the announcements in mass was also mentioned several times.

- Word of mouth in the Latino community with information coming from someone they trust—families, friends, a health worker, their cousin, their clergy
- Advertisements/Flyers that are in Spanish - concise and easy to read
- Announcements at the end of Mass
- Store Fronts
- Public Places
- Health Fairs
- Television
- Radio
- Internet

Mental Health Services Act
Prevention & Early Intervention

COMMUNITY REPORT EXECUTIVE SUMMARY COVERSHEET

Instructions:

1. Please use this form as a cover to any report you want to submit for review by the PEI Planning Panels.
2. Email this completed form and an electronic version of your report (Word document or PDF) to mhsa@acbhcs.org no later than December 14, 2007.

Organization* (if applicable) La Clinica de la Raza
Contact Person Leslie Preston, LCSW
Address 1501 Fruitvale Avenue, Oakland, CA 94601
Phone No./ Email address 535-6200, lpreston@laclinica.org

Participants in the development of this recommendation included staff, medical providers, mental health providers, board members and feedback was given by many groups including health educators, and members of the National Latino Behavioral Health Association (NLBHAI). Participants began with an extensive literature review by a UC Berkeley MSW Student. We then reviewed results from 565 community surveys that were administered to a 98% Latino population in Alameda County as part of the MHSA CSS These surveys included 49 consumers, 42 family members of adult consumers, 39 family members of child/youth consumers, 40 Older Adults, 32 "Promotoras" (volunteer health workers) , 80 individuals who were denied services because they "did not quality" for current ACBHCS services, 208 members of the general public, and 75 day laborers. Planning process as well as the input that we have received from medical staff and patients over many years about the lack of access to mental health care and the lack of services that are designed to meet the needs of the population. This paper suggest a proven effective and efficient way to reach large numbers of Latinos to provide Prevention and Early Intervention services in manner in which is culturally competent and utilizes the natural help seeking methods used by Latinos. We have visited and interviewed staff at many other health clinics (names withheld for brevity but can be provided upon request) that provide a variety of models of integrating or collocating mental health services and we believe that the particular integration model that is presented in the attached paper represents the most effective way of reaching large numbers of clients. By "nesting" a behavioral health provider into the primary care team, the following services can be provided: screening, engagement, brief treatment and referral to higher levels of care when needed by providing these services in a setting in which Latinos are comfortable and where they most often tend to seek service. Since Latinos do not tend to separate the mind from the body in their experience of distress and pain, it is natural that they would seek help in the primary care setting.

What age group does your organization serve or represent?

X Children & Youth (0-18) X Transition Age Youth (14-25) X Adults (18-59) X Older Adults (60+)

Key Community Mental Health Needs

- X Disparities in Access to Mental Health Services
- ❒ Psycho-Social Impact of Trauma
- ❒ At-Risk Children, Youth and Young Adult Populations
- X Stigma and Discrimination
- X Suicide Risk

Priority Populations

- X Underserved Cultural Populations
- ❒ Individuals Experiencing Onset of Serious Psychiatric Illness
- ❒ Children/Youth in Stressed Families
- X Trauma-Exposed
- ❒ Children/Youth at Risk for School Failure
- ❒ Children and Youth at Risk of Juvenile Justice Involvement

COMMUNITY REPORT EXECUTIVE SUMMARY INSTRUCTIONS

For questions or further information contact:
Carl Pascual at cpascual@acbhcs.org or (510) 777-2156.

SECTION I - ORGANIZATIONAL BACKGROUND:

Founded in 1971, La Clinica de la Raza is a Federally-funded Section 330 Community Health Center, and a Non-profit, 501(c) (3) tax-exempt organization. Operating at 24 sites in three counties, La Clinica is the largest community health center in the Bay Area, one of the largest in California, employing approximately 650 employees. In 2006, La Clinica served 45,152 patients of all ages with 216,676 clinical visits annually. Ninety five percent of these patients have incomes at or below 200% of the federal poverty level, and 73% are non-English speaking (this number is much higher at our Alameda County sites where over 37,000 patients are seen each year of which over 22,000 receiving primary health care services in Alameda County). Clearly such high utilization of medical services provides a unique opportunity for clinics like ours that serve the Latino population to screen Latino patients for behavioral health problems and to engage them. The attached paper documents the unusually high incidence of diabetes among Latinos and also documents the high rates of co-morbid depression among such diabetic patients, a fact anecdotally supported by primary care providers in community health clinics in Alameda County.

SECTION II - DATA SOURCES:

Disparities in Latino utilization of mental health services have been documented for some years (Hough, et al., 1987; Vega et al, 1999, Lasser et al., 2002, Chow, et al, 2003, Harris, et al, 2005),. Among Latinos with a mental disorder, for example, fewer than one in 11 contacts a mental health specialist, while for Latino immigrants; fewer than one in twenty does (A Report of the Surgeon General, 2001). The California Department of Mental Health, using their estimates of penetration rates for Medi-Cal eligible clients, show a mild improvement in the penetration rates (mental health services) for Latinos in California (~7-8% in FY 93-94 versus ~12% in FY 99-00), yet clearly much needs to be done to address such gaping disparities. A number of factors such as stigma, low rates of health insurance, paucity of culturally competent providers, and linguistic inaccessibility have contributed to this underutilization.

Alameda County Behavioral Health Care Services (ACBHCS) own data verifies that this disparity described above is true for Alameda County where Latinos are served at a rate of one third the rate of White/ Caucasian populations and at rate of one third the rate that the African American populations are served. This data is available through ACBHCS.

Sources:

Chow, J.C., Jaffe, K., & Snowden, L. (2003). Racial/Ethnic Disparities in the Use of Mental Health Services in Poverty Areas. American Journal of Public Health, 93, 792-797.

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Lasser, K.E., Himmelstein, D.U., Woolhandler, S.J., MocCormick, D., Bor, D. (2002). Do Minorities In The United State Receive Fewer Mental Health Services Than Whites? International Journal of Health Services 32, 67- 578.

Vega, W.A., Kolody, B., and Aguilar-Gaxiola, S. (1999). Gaps in service utilization by Mexican Americans with mental health problems. American Journal of Psychiatry, 156, pp: 928-934.

SECTION III - RECOMMENDATIONS:

The documented tendency of many Latinos to experience the mind and body as a unified whole, often referred to as “non-dualism” provides a unique opportunity to greatly reduce disparities in mental health utilization through the model that is presented in the attached paper. This model of providing behavioral health intervention (screening, brief treatment, and referral) as part of a primary care visit addresses the critical issue of stigma by providing behavioral health services within the primary care setting as part of a primary care visit, rather than separating these aspects of wellness which is out of sync with how Latinos experience themselves with the mind and body as a unified whole. Through nesting behavioral health services into primary care clinics, which are already trusted in the community and serve large numbers of Latinos, we believe that hundreds if not thousands of Latinos would access behavioral health services, who would not otherwise have accessed behavioral health services, if the services were properly presented. The attached paper describes a culturally based model to achieve this goal. The model centers on the inclusion of a behavioral health specialist (BHS) who is "nested" within the primary care team The attached paper outlines the model, and suggests a variety of clinical and administrative outcome measures for evaluating the effectiveness of the model. We would recommend consideration of the model presented in the attached paper. There are some significant challenges to funding this service through Primary Care funds which is why this model is being submitted for consideration under MHSA PEI. The model is based on a “warm handoff” where the Primary Care Physician personally introduces the patient to the behavioral health consultant thus leveraging the trust that the patient has in his/her medical provider. Primary care clinics cannot get reimbursed for these “same day” visits. Additionally, follow up visits are only reimbursable for Medi-Cal patients and again there is no funding source for the uninsured patients. Lastly, the Primary Care funding streams severely restrict who can provide this

service. MHSA funding would eliminate these three major barriers to being able to provide this type of Prevention and Early Intervention service to the community to address the primary issues of disparities, access to care, and stigma.

Integrated Primary Care and Behavioral Health Services for Latinos: A Blueprint and Research Agenda

(Under Review)

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Introduction

Disparities in Latino utilization of mental health services have been documented for some years (Hough, et al., 1987; Vega et al, 1999, Lasser et al., 2002, Chow, et al, 2003, Harris, et al, 2005),. Among Latinos with a mental disorder, for example, fewer than one in 11 contacts a mental health specialist, while for Latino immigrants, fewer than one in twenty does (A Report of the Surgeon General, 2001). A number of factors such as stigma, low rates of health insurance, paucity of culturally competent providers, and linguistic inaccessibility have contributed to this underutilization. The general tendency of Latinos to be non-dualistic, that is, to not partition the mind and body, as Western medicine does, provides a unique opportunity to address these disparities in utilization. The establishment and expansion of federally funded community health and migrant health centers, beginning in the 1960's, has drastically improved access to primary and specialty care services for the medically indigent. There is evidence that a substantial number of low income Latinos access health care via these centers (Politzer, et al, 2001; Regan, et al, 1999). In the state of California alone, there are 768 such non-profit community clinics that provided care to 2.8 million patients in 2004, 53 percent of whom were Latinos. (California Office of Statewide Health Planning and Development, 2004) This paper advocates a specific model of engagement of Latinos into a continuum of needed behavioral health services via the primary care clinic, and suggests a variety of clinical and administrative outcome measures for evaluating the effectiveness of the model. The model centers on the inclusion of a behavioral health specialist (BHS) who is "nested" within the primary care team. The preparation and perspectives of clinically trained social workers make them ideal for this role. The term behavioral health problems

will be used here in the broadest sense to refer to: mental health problems (diagnosable as well as "subclinical"), substance abuse problems (both abuse and dependence), and other problems caused by psycho-social stressors such as domestic violence, living with chronic disease, and others.

Health and Behavioral Health Disparities

A variety of studies, while demonstrating mixed results, have supported prevalence rates for many mental disorders among Latinos which are in line with those found in the general population (Vega, et al., 1985; Karno, et al, 1987). Major depression, however stands out as unique. A white paper by the National Council of la Raza (Institute for Hispanic Health, 2005), citing the Hispanic Health and Nutrition Examination Survey (HHANES), the Epidemiologic Catchment Area Study (ECA), and the National Co-morbidity Survey (NCS), concludes that Latinos are at high risk for depressive episodes within their lifetimes, predicting that 17.7% of Latinos will suffer from major depression in their lifetimes. The report suggests that these rates are most probably quite low due to the tendency, which will be elaborated later, of Hispanics to manifest depressive symptoms via physical complaints. Two particular intra-group variables are worthy of special note when considering rates of psychiatric disorders among Latino(a)s. Though much more investigation needs to be done, there is preliminary evidence that Latina women may be more at risk for certain types of disorders than Latino men (Koss-Choino, 1999; Rosen, et al, 2003). A second, and very important variable is acculturation, about which more will be said later.

When considering disparities in certain "physical" disorders, a somewhat clearer picture emerges.

The prevalence of diabetes among Latinos is twice that for non-Hispanic whites, (Harris, et al, 1998 A) and rates of some diabetes-related complications are also higher. (Harris, et al, 1998). Perhaps more startlingly, in 2003, Hispanics were 1.5 times as likely as non-Hispanic Whites to die from diabetes (U.S. Office of Minority Health, http://www.omhrc.gov/templates/content.aspx?ID=3324, retrieved 1/31/07). These striking disparities in diabetes rates and concomitant medical complications have resulted in serious focus on diabetes management by primary care providers who work in clinics serving Latino patients.

Comorbidity

Comorbid depression affects 15% to 30% of all adults with diabetes, and is associated with worse outcomes (Anderson, et al, 2001). It is likely that such depression is vastly underdiagnosed. Ballenger et al. (2001) estimate that physicians only recognize 50% or fewer of cases of major depression among their patients. When it is specifically screened for, Anderson and colleagues (2007) found rates more in the 30-70% range. Diabetic patients with comorbid depression have more diabetes-related symptoms, worse glycemic control, a higher prevalence of complications, and a reduced quality of life (Ciechanowski,et al, 2003; DeGroot, et al, 2001). It is not only the so called "vegetative" symptoms of depression (hypo/hypersomnia, appetite disruption) that emerge in the primary care encounter. An estimated 12% of primary care patients report persistent physical symptoms for which no good medical explanation can be found (Lamberg, 2005). Indeed, Latinos are more likely than whites to express mental distress primarily through somatic symptoms and, thus, are more likely to discuss such issues with a trusted medical provider (Escobar, et al, 1987; Kolody, et al, 1986). Such patients tend to

experience depression in the form of bodily aches and pains as in stomachaches, backaches, or headaches that persist despite medical treatment, or generalized, non-localized pain ("*Me deule en todas partes*" – I hurt all over). In addition, Latino patients may refer to symptoms that involve both physical and emotional components using terms like "*nervios*" (literally, nerves), which providers may misunderstand or misinterpret (Salgado de Snyder, et al, 2000; Jenkins. 1988) As an expression of the widespread concern over such phenomena, in 2005 The National Institute of Mental Health funded the Medically Unexplained Physical Symptoms (MUPS) in Primary Care Research Center for a five year period.

The Case for Integration

Behavioral health services, primarily mental health and substance abuse services, are generally "carved out" of health care services as far as policy, funding streams, philosophy, and research paradigms are concerned. This is the case in the public, managed care, and non-profit sectors. For the most part, behavioral health services are managed/rationed around acuity thresholds of medical necessity. Generally this means psychotic disorders and major affective disorders severe enough to be close to warranting inpatient care. Clearly, such criteria further limit access for many clients with need for services, but the need may be manifested in other ways. It is estimated, for example, that half of all mental health care is delivered by primary care providers (Narrow, et al, 1993). One survey has sixty seven percent of psychoactive agents and eighty percent of antidepressants being prescribed by primary care physicians (Beardsley, et al, 1988). There are ways, however, in which current behavioral health care provided via primary care falls woefully short. Psychiatric guideline adherent follow up for the prescription of

antidepressant medications is often not done, and counseling or other psychosocial interventions are usually absent altogether. Failure to provide such follow up can actually elevate risk, especially in the initial three months following such prescriptions. In the case of elderly patients who had successfully committed suicide, for example, one study found that seventy five percent of them had visited their physician during the previous month (SAMHSA, 2004). Additionally, a variety of studies support the finding that the combination of medication and psychosocial intervention is more effective for behavioral health problems than either alone.(Blackburn, et al, 1981; Kovacs, et al, 1981).

There are a variety of models for the integration of primary care and behavioral health services (Strosahl, 2001; Strosahl, 1998) which represent a continuum of integration:

1) The traditional "specialty" model of behavioral health care. In this model, the primary care and behavioral health clinics have separate locations, separate missions and eligibility requirements.

2) Special referral relationship. The two services have a memorandum of understanding or "preferred provider" relationship. Some information is exchanged.

3) Co-location. The health clinic has an on site behavioral health unit or team.

4) Collaborative care. The two services share the same site and cases. A behavioral health specialist acts as liaison between the two services.

5) Integrated care. The behavioral health specialist is an integrated member of the primary care team.

One Model Particularly Appropriate for Latinos – The Centrality of Relationship

Hayes-Bautista & Chiprut (1998), in an ethnographic study of the ways in which Latino physicians dealt with their Latino patients, concluded that the doctor's interactions with the patients were guided by specific cultural adaptations of clinical algorithms such as a personal, informal manner while taking medical histories. The centrality of a culturally

appropriate relationship in the engagement phase of providing treatment has been noted by several authors (Organista, 2000; Manoleas & Garcia, 2003). The balancing of respect for the client (*respeto*), with warmth and personal interest (*personalismo*) has been noted by various investigators (Rosenthal-Gelman, 2004; Lopez, et al, 2002; Manoleas, et al, 2000). The importance placed upon the relationship Latino patients have with their primary care providers supports a service model which seamlessly extends and generalizes this relationship to the behavioral health specialist. This is the so called "warm handoff" model. It differs from a traditional referral in that the introduction of the behavioral health specialist by the medical provider is done immediately following the medical encounter, in the waiting room, or, perhaps, in the exam room itself. It generally corresponds with a time of maximum emotional need on the part of the patient, but more importantly for Latino patients, the BHS is brought into the patients care *por referencia personal.* This personal vouching for the BHS, done by the primary care provider, helps extend the clinical relationship enjoyed by that provider to the BHS. This extension forms the basis for the engagement of clients, via the primary care clinic into a variety of behavioral health services.

Behavioral health specialists should be clinically trained, bi-lingual, and culturally competent social workers or psychologists. In addition, if they hold clinical licenses, in many states their services will be reimbursable. The model advocated here involves an immediate but brief encounter by the BHS focusing on screening/assessment, brief intervention, and arrangement for follow up and/or referral. Ongoing feedback to the primary care provider and bi-directional communication flow is an important element of the model. Average time for encounters should be around twenty to thirty minutes and

differs vastly from classical psychotherapy sessions. Most acute issues are often ameliorated/resolved in the initial visit with the BHS, but one or two brief follow up visits may be scheduled. Solution-focused therapy is particularly useful, as is cognitive behavioral therapy, one of the few approaches of empirically validated effectiveness with depressed Latinos (Miranda, et al, 2003). Referral to specialty mental health services is indicated for patients with diagnosable serious mental illness, and case management as well as brief marital or family sessions should also be available by referral. The proposed model relies heavily on a variety of support and psychoeducational groups. While there are limitless possibilities for the focus of such groups, some of the most important are described below.

Education/health promotion

Effective prevention and management of chronic disease requires a culturally specific approach. Not only must such services be linguistically accessible, but beliefs regarding health and illness are deeply embedded in culture. Thomas, et al (2003), for example, in a qualitative study of forty Latinos who had not been diagnosed with diabetes, found that the health beliefs of these Latinos were often similar to those found among Latinos with diabetes, but differed in some important ways. These non-diabetic Latinos held many beliefs which were inconsistent with prevailing medical knowledge. Diet and obesity were not considered to be important causes of diabetes; rather, a dreaded result of diabetes was believed to be weight loss (being "skinny"). Lack of exercise was not perceived as contributing to diabetes causation. It is clear that improved self-efficacy of symptom management, healthy lifestyle enhancement, and general prevention efforts

need to be based upon culturally competent approaches which address beliefs regarding *health and illness.*

One approach which has been found to be particularly effective with low income Latinos patients has involved the use of community based health *promotores(as). Promotores(as)* are community residents, often clinic patients themselves, who possess the linguistic, cultural, and life experience capacities to relate well with other community residents who may or may not be enrolled as clinic patients (www.migranthealth.org, retrieved 1/10/07). They provide health education and advocacy as well as building capacity in their communities (Richter, et al., 1974; Pew Health Professions Commission, 1994), and there is some preliminary documentation of the positive impact of the approach on health outcomes. Anderson, et al (2007) report the experience of one clinic in which intervention by *promotoras* is credited with helping reduce A1c levels of diabetic patients (more on this later) by .5 to 1.0 points, translating to as much as a 38% less chance of complications like eye, kidney, or foot disease. Additionally, Stefl and Prosperi (1985) suggest that information dissemination regarding behavioral health related problems can be particularly useful for Latinos and increase the utilization of services. Culturally appropriate health education for the management of chronic diseases like diabetes and asthma, and psychoeducation regarding mental disorders such as depression are important parts of the model. The use of community *promotores (as)* is one approach with proven effectiveness.

Stress Management

Cordero & Kurtz (2006) describe acculturation as the process by which immigrants/migrants acquire the values, behavioral norms, and attitudes of the host

culture without necessarily abandoning their culture of origin. They particularly found language to be the most discerning acculturation variable in this process. Torn between holding onto their traditional values and norms and adapting to the mainstream culture, Latino immigrants may experience a loss or reduction in family or social supports, drastic changes in gender-based roles, the stress of economic hardship, language difficulties, and discrimination. Individuals who perceive the changes associated with acculturation as stressful may be more vulnerable to psychological problems, such as depression and anxiety (Hovey & Magana, 2000).Acculturative stress, and stress experienced upon immigration to the U.S., has a pervasive, lifelong influence on Latinos' psychological adjustment, decision-making abilities, occupational functioning, and overall physical and mental health (Saldana, D.H.,1994; Smart & Smart, 1995). Nowhere, however, are the health costs to individual Hispanic Americans of such acculturation more clearly illustrated than in the so called "Latino Paradox". Vega, et al, (1998), in a landmark, large-scale, bi-national study, looked at Mexican-American cohorts in California who had been in the U.S. thirteen years or less, thirteen years or more, and a Mexico City sample. The study's major finding, that place of birth, and time in the U.S. had a more profound influence on the prevalence of psychiatric disorders than traditional demographic risk factors such as age, sex, or socioeconomic status, is revealing. According to these data, for virtually each disorder studied, substance abuse/dependence, depression, dysthymia, bipolar disorder, and anxiety disorder, Mexican immigrants had about half the prevalence rates of people of Mexican descent born in the United States.

Strategies for coping and managing stress should form an integral part of the behavioral health services for Latinos. The BHS can be the gateway to such services, which may be

provided individually or in groups, by psychotherapists, *promotores,* or other specially trained staff. Such services should focus on available evidence-based techniques and give particular attention to documented cultural tendencies. Enlightening in this regard is a 2006 survey completed by the Greenberg Quinlan Rosner Research Group (N=2152 adults, 434 of whom were Hispanics) which showed that the majority of their Hispanic sample was concerned about stress, and that Hispanics were more likely than other Americans to report the health of parents, family and of themselves as very significant sources of stress in their lives. The authors reported that stress was experienced differently by Hispanic men and women, and that most of the women were the "health managers" in their family. This suggests that the entry point for sharing stress and coping strategies for the entire family may be via female members.

Substance Abuse

Schmidt (2007) reports that Hispanics have higher rates of alcohol problems than blacks or whites, but were less likely than whites to get treatment. Citing access problems, the study specifically referred to financial and logistical problems, such as not knowing how to find services, lacking means to pay and being unable to obtain child care. Borges and Cherpitel (2001) sampled 537 emergency room patients from three hospitals in Pachuca, Mexico, and 332 Mexican-American emergency room patients in Santa Clara County, California, and found a prevalence of 15% for alcohol dependence and a prevalence of 28% for alcohol abuse or dependence in the merged sample. The primary care setting, via the behavioral health specialist, provides an excellent opportunity for screening, referral, and brief intervention with alcohol related problems. Fleming and Manwell (1999) found

brief social work interventions in the primary care setting for alcohol related problems to be simple, effective, and compatible with social work values. Brown at al (1997) have validated a quick, two-item conjoint screening (TICS) test for alcohol and other drug abuse or dependence using a random sample of 434 adult primary care patients. The questions: "In the last year, have you ever drank or used drugs more than you meant to?" and "Have you felt you wanted or needed to cut down on your drinking or drug use in the last year?" were utilized. The TICS was particularly sensitive to polysubstance use disorders. Respondents with zero positive responses had a 7.4% chance of a current substance use disorder (SUD), either abuse or dependence; one positive response, 45.0%; and two positive responses, 75.0%. The BHS would be in an excellent position to screen for alcohol/drug related problems, and to begin the engagement process around these issues by utilizing motivational interviewing techniques. Given the culturally appropriate family focus of most community health centers, the BHS may refer the patient, other strategic family members, or the whole family for ongoing substance abuse services.

Adjunctive approaches to Western medicine

Alternative medical therapies are gaining popularity in the United States. A 1997 survey estimated that 12.1 percent of adults in the United States had used an herbal medicine in the previous 12 months, compared with 2.5 percent in 1990 (De Smet, 2002). Studies of sub-groups of Mexican-Americans found that the percentage of people who reported consulting herbalists or traditional healers ranged from 7% to 44% (Keegan, 1996, Macias & Morales, 2000). Kuo, et al. (2004)), found that Hispanics had some of the highest rates of adjunctive herbal use, but were less likely than whites to disclose such

use to their primary care provider. Early evidence indicated that when Latinos used alternative or "folk medicine" approaches, they were not used in place of, but in conjunction with mainstream services (Martinez, 1977). Subsequent research has characterized Latinos as subscribing to "medical pluralism" (Belliard & Ramírez-Johnson, 2005), that is, a worldview which ascribes health problems to multiple knowable and unknowable causes resulting in a belief that diverse treatments are concomitantly needed. *Yerberos* (herbalists), *curanderos* (healers), *sobadores* (masseurs), or *espiritistas* (spiritualists) may be consulted from time to time, but do not take the place of visits to the medical provider. Overall quality of care for Latino patients can be optimized by acknowledging these realities and structuring groups, classes, and other modalities of consultation around adjunctive approaches, especially where incompatibilities or outright contraindications are concerned.

Evaluation Domains

The implementation of this model of integrated care for Latino patients will lend itself to a variety of paradigms for evaluating the effectiveness of the model. Administrative data can be gathered from encounter and billing forms and referral tracking systems. With involvement of the BHS as the independent variable, a variety of administrative outcomes can be evaluated. Utilization patterns of other behavioral health related services can teach us more about what culturally competent services for Latinos look like. Administrative efficiencies can be also be evaluated. We would hope to see a reduction of "inappropriate" medical visits as utilization of behavioral health services increases. We would also expect such efficiencies to result in decreased average cost of care per patient,

improved provider and patient satisfaction, and possible improvements in provider productivity. All of these hypotheses could be easily tested.

Longitudinal clinical outcomes can be evaluated following full implementation of the model. Glycosylated hemoglobin (HbA1C or A1c) is a widely accepted measure of glucoregulation. HbA1c testing determines the average blood sugar level over 2-3 months and provides information about control of blood sugar levels. It is highly specific compared with a two-hour oral glucose tolerance test (OGTT) or a fasting plasma glucose test (Lee & Safranek, 2006), and twice yearly monitoring is the standard of care for diabetics and those at high risk of developing diabetes. Changes in A1c levels can comprise a uniform dependent variable when evaluating the effects of involvement with behavioral health services for Latino patients. Changes in the number, type, and severity of medical complications, identification of psychiatric disorders, treatment adherence, and myriad other health outcomes can be evaluated as a result of behavioral health involvement versus non-involvement as control. Scales and other measurements can be created for the various "secondary" referral services made by the BHS, and can be subjected to ANOVA to see which, if any of them have more or less effect on health outcomes. Data can be readily gathered from existing medical charts, referral tracking forms which track patient flow through the newly integrated system, and the charting of the BHS.

Conclusion

This paper has advocated a model of integration of behavioral health and primary care services for Latinos which is both empirically grounded and culturally based. Community clinics, utilized by many Latino patients, provide a proven access point in the quest to

reduce Latino behavioral health utilization disparities. The model lends itself to a holistic approach, and could be expected to improve the overall quality of care, reduce a variety of risks related to physical and psychiatric disorders, increase patient satisfaction, and generally improve clinic efficiency. The proposed model centers on a behavioral health specialist who is a totally integrated member of the primary care team. Professionally trained social workers, with their "person in environment" focus, should have a central role in the planning and implementation of such a model.

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La Clínica.

Mental Health Needs in the Latino Community
Las necesidades de salud mental en la comunidad latina

All populations combined
Todas poplaciones combinadas

July 2005/*Julio 2005*

These 421 interviews were conducted by La Clinica staff and health promoters in the months of June and July. For many questions, respondants were able to give multiple answers.
421 entrevistas fueron hechas por los trabajadores comunitarias y Promotoras de salud de La Clinica en los meses de Junio y Julio. Para muchas de las preguntas, las personas pudieron dar mas de una respuestas.

Seniors/*gente de la tercera edad: 40*
Health Promoters/ *Promotoras de salud: 32*
People who need services but don't qualify for specialty mental health services/ *gente que necisitan servicios pero no qualifiquen para servicions de especialidad de salud mental: 80*
General public/ *publico en general: 208*
Day laborers/ *jornaleros: 75*

A. Demographics/Datos demográficos

1. Gender/*género* *(n=413)*
- 61%: Females/*mujeres*
- 39%: Males/*hombres*

2. Age/*edad* *(n=407)*
- *12%: <25*
- *35%: 25-34*
- *24%: 35-44*
- *14%: 45-54*
- *15%: >55*

3. What city do you live in? /*¿En que ciudad vive usted?(**n=409)***
- 85%: Oakland
- 7% San Leandro
- 4% Hayward
- 2% Alameda (1% Castro Valley, Fremont, 1% Berkeley)

4. Where is your family from? /*¿De donde es su familia?* *(n=415)*
- 76% Mexico
- 19% Central America
- 2% South America
- 2% US
- 1% Caribean

5. Primary language (*premier idioma*) *(n=415)*

98% Spanish/*español*
3% English/ *ingles*
1% Mum/Mam (indigenous Guatemalan)/*mum-(indigena de Guatemala)*

B. Past history/ *historia pasada*

6. Many people have experienced conditions of nerves, anger, fear, depression, and/or sadness. Have you or any person near to you had, any of these conditions that affected your/their health or emotional/mental well-being? *Muchas personas han experimentado condiciones de nervious, coraje, susto, depresión, y/o tristeza. ¿Ha tenido usted, o alguna persona cercana a usted, una condición como estas, que afecto a su salud o bienestar, emocional/mental* *(n=416)*

77% yes/*si*
23% no/*no*

7. Did you or the person close to you, look for any kind of help? *¿Busco usted, o alguna person cercana a usted, ayuda de alguna forma?* *(n=313)*

76% yes/*si*
24% no/*no*

8. If you looked for help, where did you? *¿Si buscó ayuda, donde?* *(n=242)*

42% doctor/ *medico (1% said Highland/ dijo Highland)*
27% agency/program/ *agencia or programa* (10% said La Clinica, 2% said Casa del Sol and 1% said Casa CHE, all departments of La Clinica)
19% family/ *familia*
18% church/ *iglesia*
14% psychologist/ *psicólogo*
13% close friend/ *comadre, compadre, amigo/a*
3% healer/ *curandero*
1% school/ *escuela*
1% return to country/ *regresar a su pais*

9. Did you find what you were looking for? *¿Encontró lo que buscaba?* *(n=242)*

70% Yes/*si*
30% No/*no*

10. (If you found what you were looking for/ *Si encontró lo que buscaba...)*
Please explain why did you find what you were looking for/ *Por favor explique porque encontró lo que buscaba.* *(n=119)*

40% they feel better/ *se siente major*
31% spoke with someone/ *hablar con alguien*
30% received services/ *recibió servicios*
18% medicine worked/ *funciono la medicina*
2% low cost or free/ *bajo costo o gratis*

11. (If you didn't find what you were looking for*/ Si no encontró lo que buscaba...)*
Please explain why / *Por favor explique por que:* *(n=70)*

49% did not receive enough help/*no obtuvo suficiente ayuda*
20% poor service*/ mal servicio*
17% medicine did not work*/medicina no funciono*
17% still have problems*/ todavia tiene problemas*
7% cost/ *costo*
6% denied services*/ negaron servicios*
4% lack of knowledge of services/ *falta de conocimiento de servicios*
4% didn't have health insurance*/ no tenia aseguranza de salud*
4% needed professional help/ *necesitaba ayuda profesional*
1% language/ *idioma*
1% legal status/ *estatus legal*
1% racism/ *racismo*

12. If you did not look for help, why not? *Si no buscó ayuda, ¿por que no?* *(n=69)*

51% lack of knowledge about services*/ falta de conocimiento de servicios*
24% did not want to look for assistance*/ no queria buscar ayuda*
6% legal status/ *estatus legal*
6% didn't have health insurance*/ no tenia aseguranza de salud*
3% fear of having a medical problem/ *miedo de tener un problema médico*
4% language/ *idioma*
4% didn't have time/ *no tenia tiempo*
1% cost/ *costo*

C. Future*/ futuro*

13. If you, or a person close to you faced this problem in the future, who would you like to talk to or where would you like to go to receive help? *Si usted or alguna persona cercana a usted se encontrase con este problema en el futureo ¿Con quien le gustaría hablar o a donde le gustaría ir para recibir ayuda?* *(n=367)*

38% Psychologist*/ psicólogo*
36% Agency or program*/ agencia o programa*
32%: Doctor*/ médico*
14% Church/ *iglesia*
9% Family/ *familia*
7% Close Friend/ *comadre/compadre o amigo/a*
2% Healer/ *curandero*

Specific detail (these responses may have fallen under several categories: doctor, psychologist or agency/ *detailles especificas (estas respuestas hubieran podido estar abajo de varias categorias: médico, psicólogo or agencia)*

10% specified La Clinica/ *dijeron La Clínica*
2% specified Casa del Sol/ *dijeron Casa del Sol*
1% specified a community clinic/ *dijeron una clinica comunitaria*
1% specified a hospital/ *dijeron un hospital*

14. What reasons make it difficult to find help? *¿Cuáles razones le hace más dificil conseguir ayuda?* *(n=376)*

64% Services don't exist or don't know of them*/ no existen, no saben si existen servicios*
42% Language and cultural appropriateness/*idioma y entendimiento cultural*
40% Cost*/costo*
36% Lack of health insurance*/falta de aseguranza de salud*
29% Transportation or too far/*transportación o demasiado lejos*
9% Schedule*/ horario*
6% Childcare*/ cuidado de niños*
3% Legal situation*/ situación legal*
1% Don't want to accept they have a problem/ *no aceptan que tienen un problema*
1% Shame*/ pena*
1% Trust/ *confianza*

15. What types of services would you like to have*? ¿Que tipo de servicios le gustaria tener?* *(n=400)*

27% Counseling/ *consejeria*
26% Spanish/*español*
25% Psychologist*/ psicólogo*
21% Free or low cost/ *servicios gratuitos o bajo costo*
17% More information*/ mas información*
11% Support groups/ *grupos de apoyo*
10% Nearby in my community*/ cerca en mi comunidad*
7% No insurance necessary/ *no aseguranza necesario*
5% Transportation/ *transportación*
4% Good treatment/ *buen trato*
3% No ID required*/ no se necesita identificación*
3% Convenient schedule/ *horario conveniente*
3% Family based services/ *servicios familiares*
2% Rehabilitation services*/ servicios de rehabilitación*
2% Natural medicine/ *medicina natural*
2% Childcare*/ cuidado de niños*
2% Services for children/ *servicios para nños*
1% Services as long as needed/ *servicios a lo largo plazo*
1% Individual attention/ *atención individuo*
1% Services in the home/ *servicios en domicilio*
1% Medical services*/ servicios médicos*
1% Relaxation*/relajación*

Mental Health Services Act
Prevention & Early Intervention

COMMUNITY REPORT EXECUTIVE SUMMARY COVERSHEET

Instructions:

1. Please use this form as a cover to any report you want to submit for review by the PEI Planning Panels.
2. Email this completed form and an electronic version of your report (Word document or PDF) to mhsa@acbhcs.org no later than December 14, 2007.

Organization: Native American Health Center
Contact Person: Janet King
Address: 3124 International Blvd., Oakland, CA 94601
Phone No./ Email address: 510:535-4440 janetk@nativehealth.org

What age group does your organization serve or represent? ALL

❒ Children & Youth (0-18) ❒ Transition Age Youth (14-25) ❒ Adults (18-59) ❒ Older Adults (60+)

Under each category, choose the item your report PRIMARILY addresses:

Key Community Mental Health Needs

❒ X Disparities in Access to Mental Health Services
❒ Psycho-Social Impact of Trauma
❒ At-Risk Children, Youth and Young Adult Populations
❒ Stigma and Discrimination
❒ Suicide Risk

Priority Populations

❒ X Underserved Cultural Populations
❒ Individuals Experiencing Onset of Serious Psychiatric Illness
❒ Children/Youth in Stressed Families
❒ Trauma-Exposed
❒ Children/Youth at Risk for School Failure
❒ Children and Youth at Risk of Juvenile Justice Involvement

For more detailed explanations of the terms above, please review the PEI Program & Expenditure Guidelines available at http://www.dmh.ca.gov/Prop_63/MHSA/Prevention_and_Early_Intervention/default.asp

NATIVE AMERICAN HEALTH CENTER
PREVENTION AND EARLY INTERVENTION COMMUNITY REPORT
Executive Summary

I. Organizational Background

The Native American Health Center (NAHC) is a non-profit tribal organization that represents the American Indian community in the San Francisco Bay Area. The Native American Health has provided medical, dental, and human services since 1972. NAHC opened the doors of the Family & Child Guidance Clinic (FCGC) in 1985 to provide much needed outpatient substance abuse and mental health services for urban American Indian/Alaska Natives. FCGC has been engaged in ongoing needs assessments and strategic planning during the past 10 years that has resulted in federal funding for treatment and prevention. Unfortunately, there has been a lack of resources for mental health services, in the area of prevention and early intervention using innovative culturally relevant models.

In 2001, the federal Center for Mental Health Services (CMHS) funded an innovative public-private partnership of NAHC with the City of Oakland to implement a system of care for Native American children and their families through the Child Mental Health Initiative. Through a consumer-driven and family-focused strategic planning effort, the community developed a "Holistic System of Care for Native Americans in an Urban Environment." This system links mental health and substance abuse, as well as treatment with prevention.

FCGC provides individual, group and family counseling, case management and cultural healing, using talking circles traditional American Indian healing. In 2006, FCGC saw 867 unduplicated clients for 5,686 client visits. 37% was for individual counseling, 17% for case management, 37% group counseling, and 9% family services. As federal funding for treatment winds down, it is our hope that Alameda County will pay its fair share to provide prevention and early intervention services for a most needy and vulnerable population.

Native Americans were left out of the MHSA planning process during the first round of Community Systems and Supports (CSS). The process at that time was confusing and left much to be desired about cultural competence with so many different meetings, flawed statistics about Native Americans and no way for Native Americans to submit a proposal. As a result, our staff and consumers met with Alameda County Behavioral Health officials and agreed to participate in the Ethnic Disparities Work Group with the goal of empowering ethnic minorities in the second round of MHSA, focusing on PEI, which seemed more appropriate funding for the holistic model developed by the Native community. The Ethnic Disparities Work Group was reconvened as a second Planning Panel, as a possible way to submit a proposal for PEI funds for Native Americans and other underserved minority groups. As part of the Ethnic Disparities Work Group, NAHC was funded a small amount to assess needs, develop a plan and write a proposal for PEI funding. This "Community Report" should serve as a way to submit our proposal directly to Alameda County.

II. Data Sources

Data sources include census data, summaries of local survey data, summaries of focus group data, and published research data. Unfortunately, there is a general lack of accurate AI/AN data on mental health needs, and even less data on mental health access through Alameda County. Published research data are collected annually through internal grant writing and needs assessment processes.

In 2007, NAHC completed, the first of its kind, an Epidemiological Profile on behavioral health patterns and risk of Native American youth and adults in Northern California. Epidemiological data was gathered from Alameda County Health Departments; California Department of Health; federal sources such as Centers for Disease Control, Indian Health Service, U. S. Census (2000), and the National Survey on Drug Use and Health. In additional the following systems have been utilized: Behavioral Risk Factor Surveillance System (BRFSS), National vital Statistics Source (NVSS), California Health Information Survey (CHIS), California Health Kids Survey (CHKS), and Substance Abuse and Mental Health Data Archive (SAMHDA).

III. Recommendations

NAHC has developed a "Holistic System of Care for Native Americans in an Urban Environment"—a community focused intervention that provides behavioral health care, promotes health, and prevents disease. The holistic system of care integrates mental health, substance abuse, and HIV/AIDS services. This integrated approach was based on a community strategic planning process that honored Native American culture and relationships. In the holistic model, mental illness, substance abuse, homelessness, poverty, crime, physical illness, and violence are symptoms of historical trauma, family dysfunction, and spiritual imbalance.

The holistic approach deals with the whole person. The emphasis is on self-help, empowerment, and building a healthy community. The holistic model links treatment, prevention, and recovery. Treatment includes mental health, substance abuse, medical care, family services, and traditional American Indian medicine. Prevention includes wellness education, HIV/AIDS prevention, substance abuse prevention, mental health promotion, and positive parenting training. Recovery includes employment, housing, and giving back to the community. The link between prevention and treatment is early intervention. Peer support is the link between treatment and recovery. Recovering individuals serve as role models linking recovery to prevention. Culture and spirituality build a strong and resilient foundation for recovery. The holistic model integrates western science with American Indian culture. Identified transformational values of the proposed Native American Health Center's Prevention and Early Intervention program include utilization of culturally appropriate methodologies; focus on wellness, resiliency, and recovery; consumer and family driven, with attention to the underserved American Indian/Alaska Native community.

The goals of our proposal are to: increase parenting skills for Native American adults, reduce the impact of trauma, grief, and loss for Native American families, reduce the impact of anger and violence on Native American youth, increase access for Native American youth to support group services, increase leadership skills for Native American youth, and increase access to Native American community events.

Talking Circles will be the basic methodology for mental health promotion, allowing participants to talk about their feelings and how to communicate with others in a culturally appropriate manner. These Talking Circles will be enhanced by community events, traditional Native American consultants, and cultural ceremonies.

Budget Requested: We request 2.5 FTE staff positions which would total approximately $297,089 per year. This would include 2 full-time mental health specialists and a half-time psychologist.

A. Identify and Address Local Community Mental Health Needs

Clearly, our major focus is on a holistic approach to reducing disparities in access to mental health services. Within that major domain, we will also address the psycho-social impact of trauma; at-risk children, youth and young adults; stigma and discrimination; and suicide risk.

Our Needs Assessment and Focus Groups identified several protective factors for planning mental health prevention and early identification. The following activities comprise our PEI proposal:

- Parenting skills support groups
- Communication skills (youth and adults)
- Domestic violence (prevention and support groups)
- Anger management/conflict resolution skills (youth and adults)
- Trauma, Grief, and Loss support groups (youth and adults)
- support groups (youth and adults)
- Youth support groups (self-esteem, identity, coming of age, gender-specific)
- Community and cultural events
    - Community Talking Circles
    - Native American cultural awareness
    - Community celebrations
    - Recovery support community events

The Native American Health Center provides services that are culturally competent in a non-traditional community setting linked with primary health services. The NAHC holistic model provides a culturally relevant focus on wellness and community support that diminishes the negative implications of stigma and discrimination by delivering services in a non-traditional community setting linked with primary health services. The Native American community has been champions at reducing stigma by resisting DSM 4 diagnosis which is often the origin of stigma for Native individuals experiencing imbalance. However we are forced to stigmatize our community members when mental health funding requires diagnosis for funding. We could do a lot with the reducing stigma and discrimination funds as it is already built into our holistic model by seeing symptoms in an individual as an indication that the whole community is suffering. The symptom bearer is not a bad person but a courageous person bearing the symptoms for the whole community.

Built into our holistic model are opportunities to heal from this history and an opportunity to learn survival skills to continue to live in the present day which is still fraught with discrimination and stereotypes about Native Americans in the media, school curriculums, state and federal policies and mental health funding. This institutionalized racism is often the beginning of emotional disturbance and early onset for imbalances for Native Americans.

B. IDENTIFY AND SERVE A PRIORITY POPULATION

Our major focus is on underserved cultural populations─ Native Americans. Within this category, using our holistic model, we will also address trauma-exposed; children/youth in stressed families; children/youth at risk for school failure; children and youth at risk of juvenile justice involvement; and individuals experiencing onset of serious psychiatric illness.

Many, if not all, Native Americans are exposed to traumatic events or prolonged traumatic conditions, including grief, loss and isolation and are unlikely to seek help from institutional mental health services. many Native Americans suffer from a condition referred to as historical trauma or intergenerational post-traumatic stress disorder, attributed to a cultural history of oppression and genocide. Native at-risk youth needing prevention and early intervention services live in high-stress families where parental conditions place children at high risk of behavioral and emotional problems, or where parents are identified with mental illness, substance abuse, serious health conditions, domestic violence, incarceration, child neglect or abuse. Adults and youth experiencing the onset of more severe mental difficulties will be identified in talking circles and referred for treatment. We would also work with the juvenile justice system to identify Native youth and provide outreach for these youth.

Many Native families live in dangerous neighborhoods and Native youth often attend violent schools creating risks for youth even when parental conditions are healthy. Schools that have culturally invalidating curriculums lacking truth in history are harmful to our children. Often the history taught in schools contradict tribal histories that Native youth are taught at home. When Native youth and parents point out these discrepancies, teachers have often responded defensively. Native parents are also victims of culturally invalidating school curriculums having gone to public schools themselves or to boarding schools where the intent was to destroy Native American identity.

C. IDENTIFY AND WORK TOWARDS ACHIEVING DESIRED OUTCOMES

Individual & Family Outcomes include: Enhanced resilience and protective factors, reduced risk factors, improved mental health status, improved parenting knowledge and skills, reduced family stress and discord, reduced violence, and increased social support.

Program & System Outcomes include: Enhanced capacity to provide prevention and early intervention programs, increase in the number of underserved populations who receive prevention and early intervention services.

Long-Term Outcomes include: enhanced wellness and resilience and reduced stigma.

Native American Health Center
Prevention and Early Intervention Program
December 14, 2007

Background

The Native American Health Center, Inc. (NAHC) is a non-profit, tribal organization with a Board of Directors that represents the American Indian community in the San Francisco Bay Area. The Native American Health Center (NAHC) has provided medical, dental, and human services since 1972 with offices in Oakland and San Francisco. NAHC opened the doors of the Family & Child Guidance Clinic (FCGC) in 1985 to provide much needed outpatient substance abuse and mental health services for urban American Indian/Alaska Natives (AI/ANs). The mission of the Native American Health Center (NAHC) is to assist AI/ANs to improve and maintain their physical, mental, emotional, social and spiritual wellness, with respect for cultural traditions and to advocate for the needs of all Indian Peoples, especially the most vulnerable members of the community. Utilizing a culturally-based holistic model that links prevention and treatment, NAHC provides integrated services in the areas of substance abuse, mental health, medical, dental, and HIV/AIDS services.

The American Indian/Alaska Native population within the San Francisco Bay Area is very diverse. According to the 2000 U.S. Census, 23,177 American Indian/Alaska Natives reside in Alameda County (7,164 age 0-18; 14,758 age 19-64; and 1,255 age 65 and older).

Generally, there is a general lack of accurate AI/AN data on mental health needs and even less data on mental health access through Alameda County. Native American Health Center's clients come from many of the 570 federally-recognized Indian tribes in the United States. American Indians from various tribes began migrating in significant numbers from the reservations to major urban areas like Oakland and San Francisco during the 1950's under the Bureau of Indian Affairs (BIA) Relocation Program. Ultimately, the BIA did not deliver on its promises of transitional assistance, resulting in a need for the urban American Indian population to create a sense of community and develop community based organizations such as the Native American Health Center to provide much needed culturally appropriate services.

Target Population

The Native American Health Center Prevention and Early Intervention program target population includes American Indian/Alaska Native children, youth, and adults. Although more than 51% served through the proposed NAHC PEI program will be children and youth, it is necessary and culturally appropriate to provide mental health prevention and early intervention services to the entire family. Identified transformational values of the proposed Native American Health Center's Prevention and Early Intervention program include utilization of culturally appropriate methodologies; focus on wellness, resiliency, and recovery; and consumer and family driven, with attention to the underserved American Indian/Alaska Native community.

NAHC's Family & Child Guidance Clinic is seeking funding through the Alameda County Behavioral Health Care Services to implement an American Indian/Alaska Native specific culturally appropriate program approach to mental health prevention and early intervention (PEI). The NAHC Prevention and Early Intervention program will increase the capacity to provide prevention and early intervention mental health services to the historically

underserved urban American Indian/Alaska Native population in an effort to improve access to mental health services, reduce disparities, and to address the current gap in mental health services provision. Mental health prevention and early interventions are consistent with the needs of already identified Mental Health Services Act PEI priority populations, specifically underserved cultural populations.

Reducing Disparities

The general lack of published research studies and data indicators from the local, state, and federal level on mental health problems within the Native American population is an indication that the AI/AN cultural population is underserved. The 2003 U.S. Commission on Civil Rights report detailed the unmet health needs of tribal people and noted that they "lagged 20 to 25 years behind the general population in health status." Native Americans are unlikely to seek help from institutional mental health services due to lack of cultural competence, traditional values, and community. The underserved American Indian/Alaska Native populations in Alameda County are unlikely to seek help from traditional mental health services due to barriers such as the lack of cultural appropriate services offered directly through the county.

Including underserved populations is a major priority in the Mental Health Services Act (MHSA). In the spring of 2007 staff of the Native American Health Center helped to initiate the Ethnic Disparities Work Group for Alameda County Behavioral Health. In the summer of 2007, Alameda County provided $15,000 to NAHC to summarize its long history of needs assessments and strategic planning and develop a proposal for PEI funding.

Within the context of reducing mental health disparities for underserved ethnic and cultural populations, the Native American Health Center's Prevention and Early Intervention program addresses the following populations: children/youth in stressed families, trauma-exposed, children/youth at-risk for school failure, and children/youth at-risk of juvenile justice involvement sub-populations.

Stigma and Discrimination

As an oppressed minority, Native Americans face discrimination and stigma. Native Americans are the *First Americans.* The U.S. Media has portrayed Indians as "the bad guys" in film and TV Westerns for over half a century. Native Americans are doubly stigmatized when they are different and classified as "mentally ill." They are very sensitive to labels. Native In 2001, through a local planning process, members of the Native American community chose to use the words "most vulnerable and needy children" instead of the term, "severely emotionally disturbed."

The long history of oppression of Native Americans in the United States has a devastating effect on the health and well being of American Indian/Alaska Natives. Examples of historical and institutional oppression include: colonization, the outlawing of Native languages and spiritual practices, forced relocation, systematic incarceration, and forced assimilation through the Bureau of Indian Affairs (BIA) boarding school system. The lasting effect of coercion, oppression, and subjugation has created overwhelming mistrust of U.S. government programs and health institutions. The distrust that Native Americans have in the health system stems from the legacies of colonization, including the decimation of thousands of tribal people from disease, the subsequent struggle for quality health care services, the breaking of treaty

rights, and the diminishing of tribal sovereignty. Resulting from mistrust of government health institutions, American Indian/Alaska Natives living in urban areas prefer to receive health services from community health clinics such as the Native American Health Center. NAHC's provision of mental health prevention and early intervention services in tandem with medical, dental, WIC, and health education services assists in reducing stigma surrounding mental health services and creating a feeling of community.

The Native American community has been champions at reducing stigma by resisting DSM-4 diagnosis which is often the origin of stigma for Native individuals experiencing imbalance. However we are forced to stigmatize our community members when mental health funding requires diagnosis for funding. We could do a lot with the reducing stigma and discrimination funds as it is already built into our holistic model by seeing symptoms in an individual as an indication that the whole community is suffering. The symptom bearer is not a bad person but a courageous person bearing the symptoms for the whole community. DSM labels also do not fit the real imbalances that Native Americans suffer from which originate with the violent history perpetrated on Native Americans by the federal government which the Surgeon General's report on *Mental Health: Culture, Race and Ethnicity* calls "legalized discrimination." Built into our holistic model are opportunities to heal from this history and an opportunity to learn survival skills to continue to live in the present day which is still fraught with discrimination and stereotypes about Native Americans in the media, school curriculums, state and federal policies and mental health funding. This institutionalized racism is often the beginning of emotional disturbance and early onset for imbalances for Native Americans.

Trauma-Exposed

Native Americans needing prevention and early intervention are exposed to traumatic events or prolonged traumatic conditions, including grief, loss and isolation and are unlikely to seek help from institutional mental health services. Many Native Americans suffer from a condition referred to as historical trauma or intergenerational post-traumatic stress disorder, attributed to a cultural history of oppression and genocide. Embedded within culturally appropriate models for mental health prevention and early intervention is the concept of Intergenerational Post Traumatic Stress Disorder (PTSD) and historical trauma influences emotional experiences and perceptional responses of childhood events that persist into adulthood. Other risk factors for Native American youth often occur due to ineffective parenting and disciplinary practices, presence of abuse in boarding schools, parental depression, alcohol-related violence, sibling alcohol use, and stressful life events, lack of nurturing, weak Native identity, and abuse resulting from historical trauma.

Trauma and Violence

Here is a list of the common themes when members of a recent focus group were asked about the types of trauma that affect the Native American community in Alameda County:

- Domestic violence
- Elder abuse
- Child abuse
- Anger and violence
- Family conflict

- Unresolved grief and loss
- Isolation
- Post Traumatic Stress Disorder
    - Intergenerational
    - Veterans

In reviewing risk factors for Native American youth living in the Bay Area and data from the clinical records of the Family & Child Guidance Clinic of NAHC, the school system, and other agencies serving Native American youth, it is estimated that 50% of San Francisco Bay Area AI/AN youth are at risk for mental illness.

Since 1979, suicide and homicide have been leading causes of death among young AI/ANs. The rate of violent victimization of AI/ANs is more than twice the national average. The higher rate of traumatic exposure results in a 22% rate of PTSD for AI/ANs, compared to 8% in the general U.S. population. Among Native youth ages 15-25, suicide has been the second leading cause of death for the past 15 years. Nationally, Native American adolescents are over-represented within the juvenile justice system and have higher rates of psychiatric symptoms. Local Needs Assessment data indicates that 69% of respondents in a 2007 NAHC health survey indicated that they were concerned with street safety 43% were concerned with gangs, and 23% were concerned with school violence.

Family violence accounts for 18% of all violent victimizations experienced by American Indians. Gender-based trauma has emerged as one of the most serious public health problems facing American Indian women today. In a study of lifetime exposure to trauma for Native American women, over half the sample experienced physical or sexual assault.

Local data from our federally funded Native American Women's Circle indicate that trauma, violence, physical abuse, and sexual abuse are high-risk factors for Native American women. Among female substance abuse clients of the Family & Child Guidance Clinic from 1999-2002, 91% indicated that they were emotionally abused in their lifetime. Also, 84% experienced physical abuse. Among youth, 74% of participants in a local EAT study reported a history of victimization, including physical, sexual and emotional violence, and 26% reported being victimized in the past 90 days. Other local data indicated that 65% reported experiencing sexual abuse in their lifetime. In a study of high-risk women at NAHC, 41% reported feeling afraid of being beaten or threatened by a sexual partner during the past 12 months. According to the 2007 Native American Health Needs Assessment, out of 495 respondents, 20% reported concern for domestic or family violence and 8% reported concern for dating violence.

Children/Youth at Risk for School Failure

Due to unaddressed emotional and behavioral problems Native American youth are at risk for school failure. Many of these high-risk youth participate in the Youth Program of the Native American Health Center, funded by the City of Oakland. These youth receive tutoring, social support, recreational activities, leadership training, health education. and referrals for behavioral health counseling.

Many Native families live in dangerous neighborhoods and Native youth often attend violent schools creating risks for youth even when parental conditions are healthy. Schools create emotional and identity risk factors for Native youth as most have culturally invalidating curriculums lacking truth in history. Often times the history taught in schools contradict tribal histories that Native youth are taught at home. When Native youth and parents point out these

discrepancies, teachers have often responded defensively. Native parents are also victims of culturally invalidating school curriculums having gone to public schools themselves or to boarding schools where the intent was to destroy Native American identity. Prior to the institution of Hintil Kuu Ca, a Native American Pre-school and Before and After school program (for grade K-5) within the Oakland Public School District Native children dropped out as early as elementary school. After the school was instituted in 1971 with culturally validating curriculum and survival skills taught to endure the mainstream school system Native children's retention in elementary school improved. However because the Oakland Public School District does not understand the significance of a culturally validating curriculum for Native Youth, Hintil Kuu Ca has received minimal support from the district to continues as a school with a Native curriculum to help retain Native elementary age youth. Native agencies such as the Native American Health Center always try to support the school with staff and funds as it is the system that engages with our youngest community members. In many schools leaning difficulties for Native youth have escalated into emotional disturbances when they are not recognized by the schools or inappropriately addressed.

The Youth Services Program at NAHC teaches Native youth survival skills on how to navigate culturally invalidating systems and also help with academic tutoring to prevent learning difficulties from becoming emotional disturbances.

Children/Youth in Stressed Families

Native American at-risk youth needing prevention and early intervention services have families where parental conditions place children at high risk of behavioral and emotional problems, or where parents are identified with mental illness, substance abuse, serious health conditions, domestic violence, incarceration, child neglect or abuse.

Children/Youth at Risk of Juvenile Justice Involvement

In 2007 NAHC staff visited juvenile hall and found out that there was no mechanism to even determine how many Native youth were admitted to juvenile hall and that there were no specific programs developed to identify and serve Native youth involved in the juvenile justice system. NAHC recognizes the importance of providing prevention and early intervention services to Native American youth who are either at-risk or have had first point of contact with any part of the juvenile justice system with signs of behavioral or emotional problems.

Mental Health and Co-occurring Disorders

Co-occurring substance abuse and mental health disorders are a significant problem among American Indians/Alaska Natives, especially within the context of an urban environment. In a pilot study funded by the Indian Health Service, a review of clinical files from 200 clients who received outpatient treatment at the NAHC Family & Child Guidance Clinic showed that 85% had a history of alcohol abuse and 73% had a history of drug abuse. Additionally, 64% of these clients were diagnosed with substance induced disorders, 58% with anxiety disorders, and 50% with mood disorders, indicating a significant number of clients with dual diagnoses of substance abuse and mental illness. Although large-scale prevalence studies of mental disorders

among AI/ANs are lacking, mental illness is a major problem for AI/ANs in a vicious cycle that includes violence, substance abuse, and other co-occurring disorders.

History of Needs Assessments in the Native American Community

The Native American community in the San Francisco Bay Area have participated in needs assessments and strategic planning efforts since 1985 and have developed sophisticated models for treatment and prevention of mental illness and substance abuse based on cultural concepts. These models have been honored nationally and statewide. In 2007, the Indian Health Service has nominated the "Holistic System of Care for Native Americans in an Urban Environment" as a best practice. In 2007, The federal Substance Abuse and Mental Health Services Administration (SAMHSA) has given the staff of the Family and Child Guidance Clinic of the Native American Health Center an Award of Excellence, for dedication to and development of integrated HIV/AIDS prevention programs, substance abuse prevention and treatment programs, and mental health services for Native Americans.

In 1985, Dr. Gerald Hill conducted the first Native American community needs assessment, a project funded by the Robert Wood Johnson Foundation. An analysis of 550 surveys of American Indian community members in the San Francisco Bay Area indicated that medical care, employment, dental care, substance abuse, mental health, housing, family services, health education, and traditional healing were perceived as major unmet needs. As a result, the Family & Child Guidance Clinic (FCGC) of the Native American Health Center was established to provide mental health and substance abuse services. As a result, the **Family & Child Guidance Clinic** (FCGC) of the Native American Health Center was established to provide mental health and substance abuse services. Initial funding of $36,000 came from Alameda County to hire a .25 FTE psychologist. That same year an additional $116,000 came from Indian Health Service through Title V of the Indian Health Care Improvement Act that set aside funds for mental health and substance abuse programs at urban Indian clinics.

In 1993, the Native American Health Center and six other American Indian organizations began to collaborate in the **Community Mobilization Project (CMP)**, a multi-year comprehensive effort funded by private foundations to assess community needs and develop a strategic plan based on a "community-as-village" response to meet those needs. Its mission was:

"To set in motion a process of change that would facilitate the efforts of urban American Indians to create the structure and means necessary to reach their social, cultural, economic, and political goals as they perceive and define them."

Stakeholders met quarterly in Community Visioning Meetings. Community Councils were established to identify issues, assess needs, and set priorities for education, health, and economic development. Strategic planning provided a rich opportunity for community participation at all levels of system design and implementation, building a sense of unity and serving as a model for future efforts. Significant input came from agency directors, staff, parents, youth, community members, traditional healers, and consumers. The need for mental health and substance abuse services was identified as one of the highest priorities in the *Strategic Plan for American Indians in the San Francisco Bay Area*, which was developed as an outcome of CMP.

In 1998, NAHC was awarded a three-year planning grant through the **Circle of Care** initiative of the Center for Mental Health Services (CMHS) to develop a system of care for Native American children and their families in the San Francisco Bay Area. In partnership with the Indian Health Service (IHS), National Institute for Mental Health (NIMH), and the Department of Justice, CMHS provided funding and technical assistance to federally recognized tribes and urban AI/AN communities to plan, design, and assess the feasibility of a culturally respectful system of care. The National Indian Child Welfare Association and the National Center for American Indian and Alaska Native Mental Health Research of the University of Colorado provided technical assistance to grantees. NAHC was the only urban AI/AN program funded in the first Circle of Care funding cycle. Our Circle of Care:

- Promoted a unifying and enduring sense of urban Indian community identity, pride and cohesion based on common traditional Native values and beliefs.
- Built leadership skills and capacity among Indian families and community-based organizations which serve the Indian community.
- Produced a strategic plan for implementing a system of care that links prevention with treatment of substance abuse and mental illness.
- Secured resources to implement our newly emerging community-based system of care.

In 1999, NAHC participated in the **American Indian Prevention Needs Assessment**, conducted by the California Department of Alcohol and Drug Programs (). Urban and rural programs serving AI/ANs were surveyed, as well as public health data. The following recommendations were made to the State of California:

- Compilation of data on American Indians with substance abuse problems in all types of mental health treatment in the state – private, county and federal, for adults and youth – would assist in identifying existing sources of care.
- In-depth studies with patients, providers, and dually-diagnosed American Indians not in care would assist in assessing the status of culturally competent mental health care around the state and the unmet needs for services.
- Services that address substance-involved American Indian parents with children, adolescents, and males and females should all be considered as separate but related needs, and might be developed in the context of holistic, family-oriented programs based in American Indian organizations.
- Current statewide initiatives to enlarge and improve treatment and prevention databases should include input from American Indian providers, including representatives from Indian Health Service (IHS) and tribal programs not in the current system.

In 2000, CMHS awarded NAHC a community action grant, entitled **Urban Indian Action Grant**, to build consensus for adoption of a system of care as an exemplary practice. As a result, the Native American community in the Bay Area approved the strategic plan developed through the **Circle of Care**. The strategic plan outlined the principal components necessary in an integrated system of community health care that links mental health, substance abuse, medical and social services based on Native American values and culture. A Needs Assessment utilizing the Community Readiness Model was conducted in relation to two issues: substance abuse and mental health.

There was a unanimous level of concern for issues on youth mental health and substance abuse as evident in a consistently high score. Respondents emphasized that their agencies routinely provide information about all culturally relevant programs and resources available for

their clients. NAHC was consistently identified as a main resource for addressing these issues. Key informants acknowledged only Indian agencies as service providers and almost never mentioned the vast county, city and non-Native community organizations. Talking circles and Pow-wows were acknowledged as venues for communication, and Native agencies were recognized as primary referral resources.

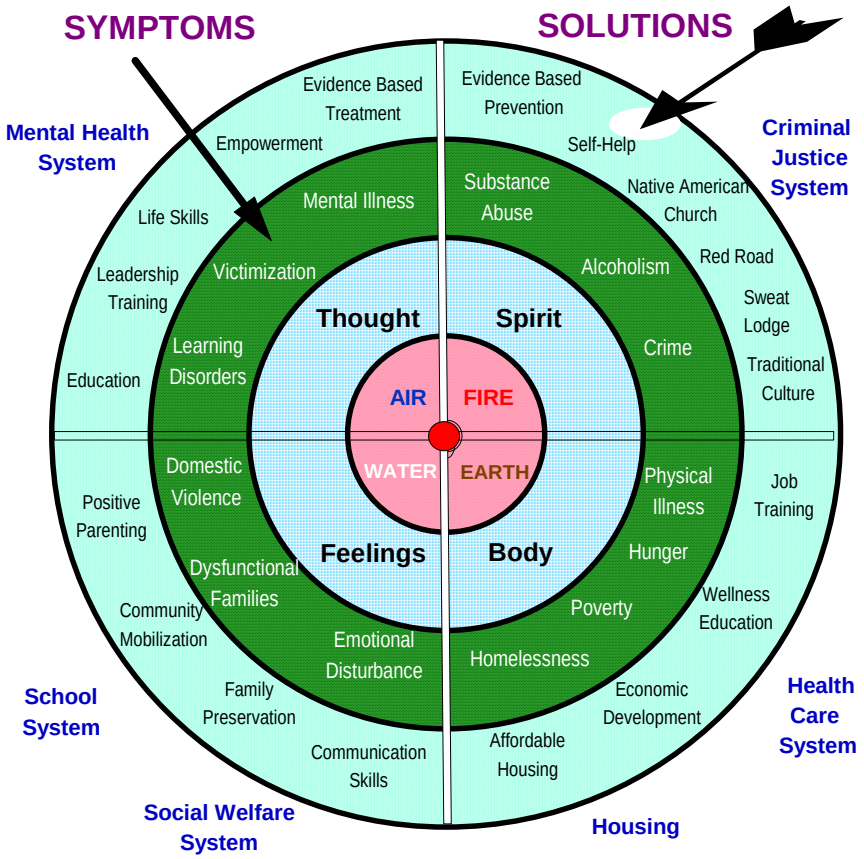
The NAHC holistic system of care model program developed a strategic plan with the following recommendations in the areas of program development, mental health reform, family advocacy, youth leadership, and wellness education:

- Develop cultural competency training for public officials.
- Develop mental health programs that strengthen the family.
- Support advocacy efforts of parent groups
- Ensure that parents and family members play an essential role in providing input into implementation of new programs.
- Expand leadership training opportunities for youth.
- Work with juvenile justice officials to develop programs for Indian youth.
- Advocate for a holistic system of care as an alternative to the medical model.
- Advocate for set-aside funding for Native American programs.

In 2001, the Center for Mental Health Services (CMHS) funded Oakland's Department of Human Services in collaboration with NAHC in a two-year project called **All My Relations**. The City of Oakland sub-contracted with NAHC to reduce mental health disparities for Native Americans in Oakland and improve mental health service delivery in non-mental health settings such as community clinics. Significant outcomes of **All My Relations** included improved access to services, formation of new partnerships between public agencies and community-based organizations serving Native Americans, integration of consumers into the planning process, and an increased sense of empowerment for community members. In addition, the strategic plan was further refined in a document entitled *All My Relations: Holistic System of Care for Native Americans in an Urban Environment.* The plan linked treatment with prevention; mental health with substance abuse; and evidence-based practices with cultural healing. This model has been instrumental in obtaining federal for treatment efforts, most notably funding for the Children's Mental Health Initiative, a 6-year CMHS grant in 2003 that ends in 2009. This project, Urban Trails, is funded at a rate of $900,000 per year. It supports virtually 99% of the mental health services at the Native American Health Center. Its purpose is to implement a culturally competent, holistic system of care for Native American children and their families. It is essential that NAHC receive funding from Alameda County to continue to provide mental health services as federal funding diminishes.

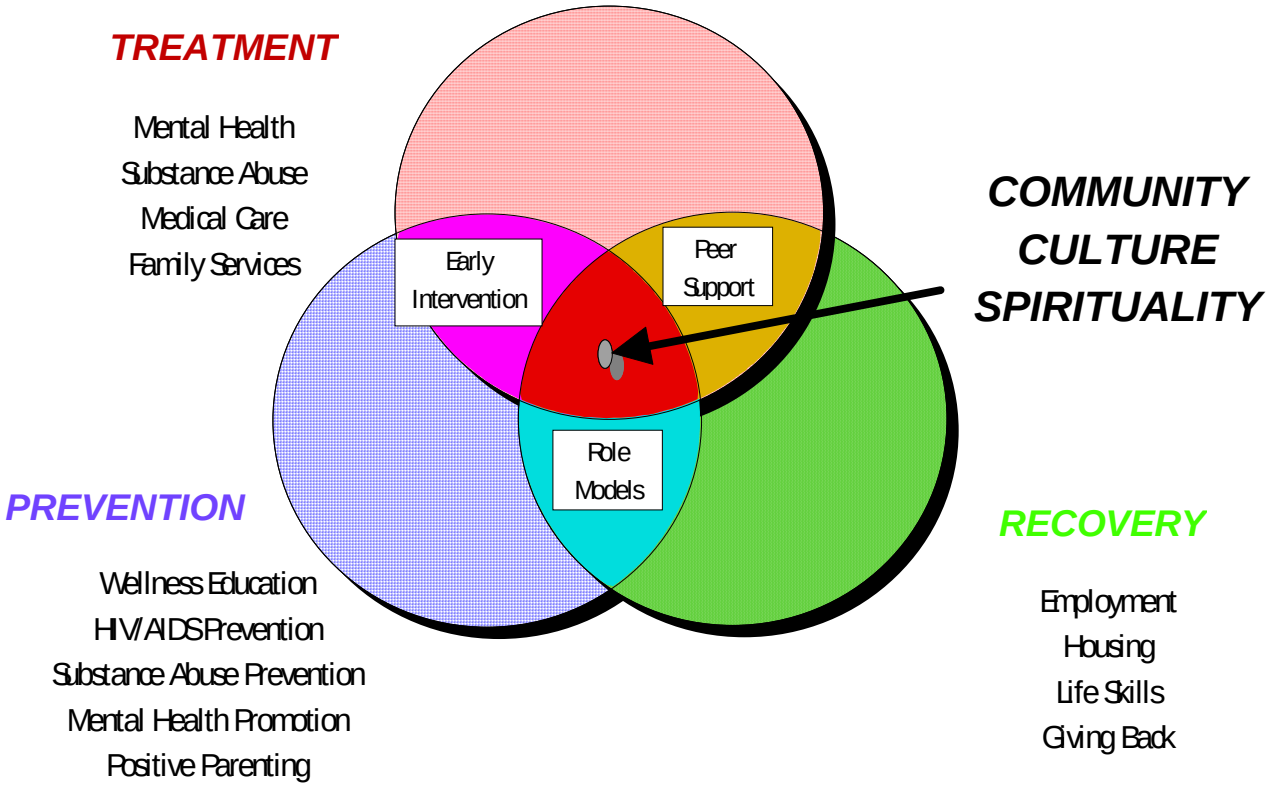
Native American ceremonies are intended to actually transform an individual's capacity and attitude, rather than just teach them how to adjust to certain circumstances. The holistic system of care is an evidence-based culturally appropriate approach to providing mental health prevention and early intervention. With a healing approach to healing the mind, body, heart, and spirit, Native American clients have a greater chance at successful participation The Native American community views mental illness, substance abuse, HIV/AIDS, homelessness, poverty, and violence are symptoms of historical trauma, family dysfunction, and spiritual imbalance. The Native American Health Center model focuses on the whole person in the context of the immediate and extended family, ancestral history, and social environment. It encompasses the mind, body, spirit, and emotions. It emphasizes assets rather than liabilities. It strives for balance,

internally and externally. It functions on individual, family, and community levels (Nebelkopf and King, 2003).



Holistic System of Care for Native Americans in an Urban Environment

The Medicine Wheel, a concept central to the cultures of many Native nations, illustrates the importance of balance for wellness. While the Medicine Wheel has many different levels of meaning, its basic elements are a circle divided into quadrants. There are many layers of symbols associated with different parts of the wheel. All areas must be in balance and harmony for true wellness to exist. A problem in one area upsets the balance and affects other areas. Traditional Native American wellness approach focuses on *rebalancing* or treating community and individual spiritual, emotional, mental, and physical imbalances. Wholeness of individuals, families, communities, and nations are all facets of wellness. Too often, indigenous people have been and continue to be defined by others—which is disempowering, demoralizing, and often devastating to the sense of self. Wholeness reinforces and is reinforced by a sense of cultural identity. It is crucial to the well-being of Native communities to retain the ability to define and name themselves, as well as to address imbalances in a culturally-congruent way. The picture below depicts the relationship of prevention, treatment, and recovery in the holistic model (Nebelkopf and King, 2004).



Holistic Model Linking, Prevention, Treatment and Recovery

Our continuum of care links prevention, treatment, and recovery. Treatment consists of mental health, substance abuse, medical, and family services. Prevention includes wellness education, positive parenting, mental health promotion, substance abuse prevention, hepatitis prevention, and HIV/AIDS prevention. Recovery includes, employment, housing, life skills and giving back. The link between prevention and treatment is early intervention. Peer support is the link between treatment and recovery. Recovering individuals serve as role models linking recovery to prevention. Community, culture, and spirituality build a strong and resilient foundation for recovery.

In 2005, the Center for Substance Abuse Prevention (CSAP) funded **Native Voices** to implement the Strategic Prevention Framework for Native Americans in the San Francisco Bay Area. **Native Voices** is a collaboration of the Native American Health Center and Friendship House Association of American Indians, Inc.— two urban Indian organizations dedicated to providing substance abuse, mental health, medical, dental, and HIV/AIDS care for American Indians and Alaska Natives (AI/ANs) in the San Francisco Bay Area. Utilizing a culturally-based holistic model that links prevention and treatment, NAHC provides integrated services in the areas of substance abuse, mental health, medical, dental, and HIV/AIDS services. The recommendations were as follows:

- Develop new programs consistent with the *Holistic Model for Native Americans in an Urban Environment* —a model that links prevention with treatment, substance abuse, HIV/AIDS, mental health, and physical health in an integrated system of care.

- Develop prevention programs that link prevention, treatment, and recovery in a continuum of care of early intervention, peer support, and role models.
- Develop prevention programs with Native American spirituality and culture at the core, as reflected in the ***Gathering of Native Americans (GONA)*** models.
- Build a stronger, healthier community that sustains itself over time.

In 2006, NAHC was awarded another 5-year CSAP grant, **One With All**, to implement a culturally competent version of the strategic prevention framework in Alameda County, San Francisco, Sacramento, and San Jose using the holistic system of care for Native Americans in an urban environment. As part of this grant, NAHC completed in 2007, an Epidemiological Profile on behavioral health patterns and risk of Native American youth and adults in Northern California. Although the CSAP funding focused on developing evidence-based programs for the prevention of substance abuse, the holistic system of care emphasizes the links between substance abuse and mental illness. By funding the NAHC Prevention and Early Intervention Program in Alameda County to add a mental health component to our existing prevention program, this would reflect a substantial leveraging of dollars and a synergistic effect (local and federal funding; substance abuse prevention and mental health promotion). This leveraging will significantly improve behavioral health services for Native Americans in Alameda County.

The Native American strategic planning process from 1998 through 2007 revealed that Native American community members expressed distaste for DSM-IV diagnostic labels. Furthermore, community members did not distinguish among the different labels provided by the social institutions, nor did they distinguish between substance abuse and mental illness. The following is a quote from the 2005 needs assessment conducted by NAHC:

"Programs are available. The problem is when we refer the client to county programs they get lost."

As a part of the Native American Health Center's Prevention and Early Intervention planning process, a focus group was conducted on September 21, 2007 asking for community input on mental health protective factors to be utilized in this program. Of the 25 participants of the focus group, approximately 20% were providers, 65% were consumers, 10% were family members of consumers, and the remaining 5% were community members. All of the providers worked in the substance abuse and mental health field with the majority of clients being Native American.

In response to the question of identifying the main mental health issues, the common themes included the following needs:

- Lack of early identification of mental health problems (adults and at-risk youth)
- Lack of support groups for families of individuals with mental health problems
- Support for military and veterans with mental health problems/PTSD
- Substance abuse and alcoholism
- Historical trauma
- Domestic violence
- Family conflict
- Feelings of isolation/lack of involvement with the Native American community
- Unresolved grief/loss
- Poverty
- Lack of parenting skills

- Lack of culturally-appropriate mental health services
- Mistrust of institutional mental health services

In addition, the following items were identified as those needing most attention:

- Lack of early identification of mental health problems (adults and at-risk youth)
- Lack of support groups for families of individuals with mental health problems
- Historical trauma
- Lack of parenting skills
- Domestic violence
- Family conflict
- Feelings of isolation/lack of involvement with the Native American community
- Unresolved grief/loss

"Its hard to talk about…my brother passed away last year because there were no services for the mentally ill – more services are needed so their choices are not either dead or in jail. We need more support for families of the mentally ill."

In response to the item of what prevents Native Americans from seeking out mental health services from the county, the most common response is that the Native American community turns to community based organizations such as the Native American Health Center for culturally appropriate mental health services rather than seek out services from county or institutional mental health facilities. Another common response is that many feel a deep-rooted mistrust of government services in general, and specifically the lack of cultural competence. The biggest barrier reported was the lack of cultural competence and mistrust of government institutions are generally the biggest barriers to navigating the system as it is. Native Americans prefer to seek the comprehensive array of services offered at Native American specific community based clinics. It is essential to provide culturally appropriate mental health prevention and early intervention is essential in order to reduce disparities for underserved populations such as the Native American community in Alameda County. As for what changes community members wanted to see the following quotes apply:

"The kind that fits me"

"It is a blessing that the Native American Health Center is here for the Indian community and that you are asking for our ideas to give to the county"

"There are so many needs in our community and I hope you are funded because we need more services from you so that our people will be in a good way"

Many of the providers mentioned that trauma was major problem within the context of the Native American community. Within a community context, providers of mental health and substance abuse working with the Native Americans often refer to the interchangeable terms of "Historical Trauma" or "Intergenerational Post Traumatic Stress Disorder (PTSD)" which has

been researched by Maria Yellow Horse Brave Heart. Historical trauma refers to a common thread many Native Americans experience of being exposed to traumatic events or prolonged traumatic conditions, including grief, loss and isolation which has been past down from generation to generation. Contributing factors include: European imperialism; relocation of Native Americans from their original tribal lands to reservations; and Bureau of Indian Affairs (BIA) policies of taking children away from their homes into boarding schools to be assimilated into Western culture. All of these factors contribute towards the mistrust of government and makes Native Americans unlikely to seek help from institutional mental health services.

A summary of the results of the Native American community focus group identified several protective factors for planning mental health prevention and early identification. The most common identified protective factors and services include parenting skills, communication skills for youth and adults, domestic violence education/support, anger management/conflict resolution skills, trauma support groups, grief/loss support groups, youth support groups, and community/cultural events.

- Parenting skills support groups
- Communication skills (youth and adults)
- Domestic violence (prevention and support groups)
- Anger management/conflict resolution skills (youth and adults)
- Trauma, Grief, and Loss support groups (youth and adults)
- support groups (youth and adults)
- Youth support groups (self-esteem, identity, coming of age, gender-specific)
- Peer mentors (older youth mentoring younger youth)
- Community and cultural events
    - Community Talking Circles
    - Native American cultural awareness and history class
    - Community celebrations
    - Recovery support community events

Risk and Protective Factors

Risk factors for Native Americans (AI/ANs) include poverty, unemployment, historical trauma, contemporaneous trauma, violence, child abuse and neglect, negative role models, and easy availability of alcohol and drugs. Other school risk factors include invalidating school curriculums which undermine Native American identity NAHC Youth Services are equipped to combat this as many of the staff are survivors of hostile school environments against Native American culture and history. Resiliency factors include strong group affiliation, extended family, cultural respect, spirituality, community support, wisdom and strength of elders, and sense of humor.

Native culture traditionally honors and gives guidance to all age groups. This honor and attention through ceremonies at various developmental stages in a person's life is not contingent on achievement but by simply being here to foster good self-esteem . Many of these cultural elements which serve as protective factors during adversity have been reinvented in our "Holistic Model for Native Americans in an Urban Environment."

The National Survey on Drug Use and Health (NSDUH) collects data on a variety of risk and protective factors found to be associated with youth substance use. The NSDUH report, *Risk and Protective Factors for Substance Abuse among American Indian or Alaska Native Youths,*

looked at risk and protective factors for substance use among 46,310 respondents aged 12 to 17 (representing a national population of 25 million) comparing American Indian or Alaska Native youths with youths among all other racial/ethnic groups combined. The focus is on American Indian or Alaska Native youths and their higher levels of risk factors or lower levels of protective factors compared with youths of other races. Three categories of risk and protective factors were examined: individual/peers, family, and school (SAMHSA, 2004).

A larger percentage of American Indian or Alaska Native youths perceive moderate to no risk of substance use compared with youths in other racial/ethnic groups Individual and peer protective factors studied were participation in youth activities and the importance of religious beliefs. A larger percentage of AI/AN youth did not perceive strong parental disapproval of youth substance use compared with youth in other racial/ethnic groups American Indian or Alaska Native youths were less likely to have participated in two or more youth activities than youths in other racial/ethnic groups. A smaller percentage of American Indian or Alaska Native youths attended religious services on a regular basis than youths in other racial/ethnic groups. Fewer American Indian or Alaska Native youths also agreed that religious beliefs are a very important part of their lives compared with youths in other racial/ ethnic groups. Parental monitoring is significantly less in AI/AN families and parental disapproval of cigarettes, alcohol and marijuana is less than in other ethnic groups

An important risk factor for youths is poor school performance. A similar proportion of American Indian or Alaska Native youths (9%) and youths in other racial/ethnic groups (6%) reported a D or lower average for the past semester or grading period. Urban Indian youth have higher risk due to a need to heal the communal trauma without having a connection to their culture and spiritual community. Many American Indian prevention programs invite community elders to participate. Elders and medicine men and women are indispensable to youth relearning Indian cultural values because they are the transmitters of the culture. In the urban Indian landscape it is often hard for youth and their families to connect with faith-based and culturally specific activities, increasing the risk of youth not having the cultural resilience and support needed to combat the increased risk factors of urban life. The absence of religious beliefs and structured faith-based practices by Native Americans can lead to increased risk for mental illness, violence, and substance abuse. The breakdown in spirituality, caused by intergenerational post-traumatic stress disorder in Native American communities, contributes towards feelings of isolation, depression, and mental health problems.

Social and environmental issues such as unemployment, poverty, poor housing conditions or the lack of housing create an environment of stress and anxiety that does not encourage youngsters to learn, to play, and to live healthy lives. The availability of drugs and alcohol, social messages about the desirability and benefits of substance use, social and domestic violence, as well as a lack of knowledge or resources of alternative healthy practices all work together to create an environment that contributes to high risk of substance abuse and mental illness. The historical trauma of the American Indian people has its roots in devastating losses of land and the collective memory of past massacres such as those that occurred at Wounded Knee and Sand Creek. At one time, elimination of the American Indian population was the policy of the Federal Government. The Government also removed generations of American Indian children from their families and put them in abusive boarding schools. The repercussions of genocide include historical trauma in Native communities that leads to substance abuse and co-occurring mental health issues, increasing risk to Native American populations in all realms of community healing

and recovery. It has been demonstrated that pervasive historical trauma can be released in a well-planned communal intervention.

In Native American families, spirituality is wrapped into everyday life rather than reserved for Sunday services.

"Traditional healers give us spiritual guidance. Call them in, different medicine people from different tribes. They provide healing, ceremonial, ancestral and indigenous ways."

For Native American youth, there is a particular approach known as the GONA (Gathering of Native Americans) that is a four-day gathering where youth begin to break down the effects of colonization and increase resiliency through education and cultural activities. The process creates connections to family, culture, teachings and belonging, which colonization and assimilation have dismantled from the Native family structure. After a SAMHSA-funded GONA was held in 2004 it was found that 83% of the youth stated they had learned more about Native American culture; 79% stated that they felt more connected to the Native American community; 79% felt they would be more involved in community activities; and more than half (55%) reported that their drug refusal skills improved (Aguilera & Plasencia, 2005).

The results of local focus groups indicate that community members embrace traditional Native American spirituality as a resource for mental health. Attending ceremonies helps reinforce the principles of wellness and give participants the community support and personal strength that is needed to confront issues of substance abuse and sexual risk factors.

Native adults naturally care for Native youth and other members of the community. This is why events is an important part of the holistic model because by bringing Native community members together, opportunities are created for adult/youth mentoring and youth/ younger youth mentoring. Native events and ceremonies traditionally include all ages. Events are important venues to transmit culture to the next generation by the planned program as well as by the informal visiting that take place. Strong identity with many mentors has long been a protective factor in Native communities. Bringing the community together also helps to heal from historical trauma in which Native children were separated from the adult members of their community for the duration of their childhoods while in boarding schools or because of forced adoptions. Protective factors for Native Americans living in the San Francisco Bay Area across a variety of domains are summarized below.

<u>Individual Protective Factors</u>

- Participation in youth activities
- Positive self-esteem
- No gang affiliation

<u>Family Protective Factors</u>

- Good parent-child communication
- Parental encouragement and monitoring
- Parents do not use drugs or alcohol

<u>Peer Protective Factors</u>

- Positive peer role models

- Peers share spiritual beliefs
- Clean and sober organized peer activities
- Participation in cultural youth activities

School Protective Factors
- Participation in tutoring in the NAHC Youth Program
- Participation in NAHC after school program.

Faith-based Protective Factors
- Participation in Native American Spiritual Practices
- Participation in Native American Medicine People and Spiritual Leaders
- Participation in Sweat Lodge
- Participation in Red Road to Recovery

Community Protective Factors
- Clean and sober role models
- Participation in Powwows
- Participation in Gathering of Native Americans (GONA)
- Participation in Tribal Athletics Program
- Participation in Community Parents Advisory Council
- Participation in Talking Circle support groups

Society / Environmental Protective Factors
- Alcohol and drug-free human service agencies
- Participation in cultural activities and ceremonies
- One With All community training
- Rebuilding traditional Native American culture

Cultural Approach to Prevention and Early Intervention

The NAHC PEI program will focus our proposal on the prevention domain in our model, including early intervention, which is conceived as the link between prevention and treatment. Culturally appropriate mental health service methodologies for the Native American population do not distinguish between prevention and early intervention. Of all the types of services in the prevention domain, mental health promotion, communication skills, trauma exposure, positive parenting, and community events will be emphasized. culturally appropriate best practices such as traditional healers, talking circles, and community events will improve the quality of care and reduce disparities. The following culturally appropriate mental health prevention and early intervention best practices and evidence based practices will be utilized throughout this program:

Gathering of Native Americans (GONA)

The Gathering of Native Americans (GONA) is a three-day gathering where youth and/or adults learn to break down the effects of colonization and increase resiliency through education and cultural activities. The process creates connections to family, culture, teachings and belonging, which colonization and assimilation have dismantled from the Native family structure

The GONA curriculum was developed in conjunction with the SAMHSA Center for Substance Abuse Prevention's Community Partnership Training Project in 1994 in consultation with a team of Native American trainers and curriculum developers from across the United States. GONA is an exemplary practice recognized by Indian Health Service and SAMHSA, addressing alcohol, drug abuse, mental illness and the deep spiritual illness underlying these symptoms. The GONA model focuses on inclusion, along with the value of each individual present, and the responsibility each member can assume to promote healing and the creation of a safe and nurturing environment in which participants can heal. Community healing from historical and cultural trauma is a central theme of the GONA approach. This includes an understanding and healing of self, family and community. The curriculum focuses not only on alcohol and substance abuse, but the many mental health issues underlying the high risk factors for Native Americans for addictions and self-destructive behaviors. The curriculum recognizes the importance of Native American values, traditions and spirituality play in healing from the effects of historical trauma, substance abuse and mental illness.

Talking Circles

Talking circles are used by various Native American communities for both community and individual health interventions. The Talking Circle is an excellent basic methodology for mental health promotion in Indian communities. NAHC has used the talking circle to enhance positive parenting, anger management, relapse prevention, family health, recovery support, communication skills, life skills, substance abuse and AIDS prevention, men's, women's and youth groups. The overarching goal of talking circles is to get participants to talk about their feelings and learn how to communicate with others.

Community Events

These Talking Circles will be enhanced by community events, traditional Native American consultants, and cultural ceremonies. One of the distinguishing factors contributing to the effectiveness of Native American traditional approach to healing for medical and mental health problems is based on addressing the physical, mental, spiritual, physical, and environmental health dimensions within the context of the individual person. Community events are held seasonally and include Gathering of the Lodges, Thanksgiving, Christmas, Halloween, Spring Celebration, and Summer Festival.

Goals and Objectives

The overall purpose of the PEI program is to reduce disparities in accessing mental health services for the Native American population in Alameda County. Towards this purpose, the following table lists the PEI program goals, objectives, and desired outcomes:

Goal 1: To increase parenting skills for Native American adults.	
Objective 1	Develop a culturally appropriate curriculum for a six week talking circle on the topic of Positive Parenting for adults, using the evidence-based curriculum, Positive Indian Parenting.
Objective 2	Design a pre and post test survey to measure increase in positive parenting skills.
Objective 3	Facilitate a six-week Positive Parenting talking circle session for 12 participants.

Expected Outcome: By the end of the six-week session, participants will have a greater knowledge-base on topics of positive parenting, anger management, and domestic violence, as indicated by informal feedback and a pre and post test survey.	
Goal 2: To reduce the impact of trauma, grief, and loss for Native American families.	
Objective 1	Develop a culturally appropriate curriculum for a six week talking circle on the topic of Trauma, Grief, and Loss for families.
Objective 2	Design a pre and post test survey to measure knowledge gained in coping with trauma, grief, and loss.
Objective 3	Facilitate a six-week Trauma, Grief, and Loss talking circle session for 5-10 participants.
Expected Outcome: By the end of the six-week session, participants will learn coping skills on how to deal with grief, trauma, and loss, indicated by informal feedback and pre and post test survey data.	
Goal 3: To reduce the impact of anger and violence on Native American youth.	
Objective 1	Develop a culturally appropriate curriculum for a six week talking circle on the topic of Anger Management and Violence Prevention for youth.
Objective 2	Design a pre and post test survey to measure knowledge gained in managing anger and reducing violence.
Objective 3	Facilitate a six-week Anger Management and Violence Prevention talking circle session for 12 participants.
Expected Outcome: By the end of the four-week session, participants will learn coping skills on how to manage anger and prevent violence, as indicated by informal feedback and pre and post test survey data.	
Goal 4: To increase access for Native American youth to support group services.	
Objective 1	Facilitate an ongoing weekly Youth Support Group on various topics, including, self-esteem, coming of age, traditional values, communication skills, and leadership for a core group of 12 Native American youth.
Expected Outcome: More Native American youth will participate in PEI youth support activities.	
Goal 5: To increase leadership skills for Native American youth.	
Objective 1	Plan and facilitate a ten-session summer leadership skills class for transition age youth.
Objective 2	Plan and facilitate a Gathering of Native Americans (GONA) three-day workshop for 25 youth.
Expected Outcome: By the end of the leadership training classes and GONA workshop, participants will improve leadership skills, learn the effects of colonization, increase resiliency through education and cultural activities, and feel more connected to the American Indian community as indicated by informal feedback and pre and post test survey data.	
Goal 6: To increase access to Native American community events.	
Objective 1	Plan and implement four cultural awareness events or activities for 200 community members
Objective 2	Plan and implement the “Gathering of the Lodges” recovery support community event for 300 community members.
Expected Outcome: More Native Americans will feel a sense of connection to the Native American community, as indicated by informal feedback and a community needs assessment survey.	

Note: The talking circles will be held on a cyclical basis, several times a year. In that way participants will be able to connect with prevention and early intervention activities. Those participants that need mental health treatment services will be referred to treatment that will be provided through other contracts and grants.

Evaluation Methodology

The evaluation methodology for the PEI program consists of both process and outcome evaluation methodologies. Taking into consideration a culturally appropriate approach to

program evaluation, informal feedback, participant storytelling, and talking circles provide a wealth of qualitative information which will be summarized by program staff in monthly report formats. Pre and post-test surveys will be utilized to measure the impact of the program on participants. We plan to serve, on an annual basis, 60 youth and 40 adults (total 100) in the talking circles and 400 community members (youth and adults) in the community events.

Individual & Family Outcomes include: Enhanced resilience and protective factors, reduced risk factors, improved mental health status, improved parenting knowledge and skills, reduced family stress and discord, reduced violence, and increased social support.

Program & System Outcomes include: Enhanced capacity to provide prevention and early intervention programs, increase in the number of underserved populations who receive prevention and early intervention services.

Long-Term Outcomes include: Enhanced wellness and resilience and reduced stigma.

Program Budget

The program budget will be $297,089. This includes two full-time mental health specialists, a half-time psychologist , and clinical director at .10 FTE for a total of 2.6 FTE staff positions. One mental health specialist will work with adults and the other will work with youth.

Personnel			
Mental Health Specialist (1.0 FTE)	$50,000		
Mental Health Specialist (1.0 FTE)	$50,000		
Psychologist (.50 FTE)	$40,000		
Clinic Director (.10 FTE)	$10,000		
		$150,000	
Fringe Benefits @ 30%		$ 45,000	
TOTAL PERSONNEL		$195,000	
Rent	$24,000		
Community Events	$13,000		
Program Supplies	$2,400		
Office Supplies	$1,221		
Telephone	$2,400		
Utilities	$2,400		
Incentives	$4,500		
TOTAL OTHER	$49,921		
TOTAL DIRECT			$244,921
Indirect @ 21.3%			$52,168
TOTAL			$297,089

Conclusion

"Indian people go on for years, with funding, without funding, and have learned to do the best with what they get—but they survive."

Native American Health Center is working in several different areas to achieve long-term sustainability. Our sustainability strategy is based on four principles:

- Reliance on multiple funding streams
- Building equity in our community
- Strong advocacy efforts at all levels
- Developing a stronger, healthier community
- Leveraging federal and local dollars

NAHC has developed a funding strategy that emphasizes the development of a diverse funding base, including federal, local government, state government, private foundations, individual donors, and third party payment. NAHC has a history of sustainability. We have developed a strategy for sustaining programs and services throughout grant cycles. Since 1998, the Family & Child Guidance Clinic has grown from a staff of 4 to 47, significantly increasing service capacity and variety of programs offered to our community. FCGC receives funding from the Indian Health Service, Center for Substance Abuse Treatment, Center for Substance Abuse Prevention, Center for Mental Health Services, Center for Disease Control, Health Resources and Services Administration, Alameda County, City of Oakland, State of California, and private foundations. Our purpose is to build a stronger, healthier community, and to sustain this growth despite the vicissitudes of any particular funding stream.

Nevertheless, it is essential, with federal funds diminishing, that Alameda County rises to the occasion to contribute its fair share to keep our programs with excellent track records moving into the future.

NAHC programs are developed to serve the needs of our clients and community. Each department is dedicated to providing culturally, socially and professionally appropriate services tailored to meet the goals and mission of the organization. NAHC has developed effective delivery of services that meet the needs of our community and clients. The strategic planning, assessment and evaluation processes, along with professional and community inquiry, supply data that help guide the development of sustainable and successful program delivery. All NAHC events and services are documented and tracked from intake to discharge

NAHC regularly contributes to national and international think tanks of research on community and family support, diagnosis, treatment and recovery. Dedication to NAHC's mission demands that, through evaluation, assessment and tracking, the clinic gets a feedback loop that includes all key informants as well as internal participants, clinicians, and staff. The data collected is recorded in quantifiable and narrative formats to show successes and challenges in program delivery and outcomes. As it is harder to quantify things like cultural competency, personal stories, surveys and feedback from the community are used for program improvements.

Dissemination of information around Native Americans and substance abuse, HIV/AIDS, and mental health issues is important in developing Native-specific evidence-based practices, continuous quality improvement, and sustainability. Staff disseminate data compiled by our Research and Evaluation Department in a number of internal and external venues: weekly clinical staff case conferences, quarterly staff trainings, national and local conferences, and in publications and in books, for example.

Healing and Mental Health for Native Americans: Speaking in Red, edited by E. Nebelkopf and M. Phillips, AltaMira Press, Walnut Creek, CA, 2004.

Morning Star Rising: Healing in Native American Communities, A Special Theme Issue of the Journal of Psychoactive Drugs, edited by E. Nebelkopf and M. Phillips, Volume 35, 1, 2003.

See appendix for references and publications by staff members of the Family & Child Guidance Clinic of the Native American Health Center which served as documentation for the identification of the "Holistic System of Care for Native Americans in an Urban Environment" as a best practice by the Indian Health Service.

The AI/AN population within the San Francisco Bay Area is very diverse. Each tribe has its own language, customs, and ceremonies. Participants in our programs have ample opportunity to experience traditional Native American medicine, spirituality, and culture. Our program acknowledges the diversity of healing beliefs among the different tribes and encourages clients to integrate these cultural practices into their lives. These culturally appropriate practices and policies will improve prevention of mental illness and substance abuse because they serve as incentives for community members to participate and increase the retention rate.

American Indian cultural healing includes prayer, singing, drumming, Sweat Lodge, smudging, herbs, talking circles, pipe, tobacco, and other spiritual ceremonies. Equally important are community celebrations, where 300-500 members of the Indian community come together to honor individuals, listen to drumming, pray together, share food, and interact with positive role models. American Indian culture should be integrated into our programs in the following ways:

- Acknowledgment of spirit in every aspect of life.
- Teaching about the essential need for balance and harmony in everyday life.
- Using the Talking Circle in its traditional form for group discussions.
- Exposure to positive role models in the American Indian community.
- Opportunity to participate in ceremonies and meetings with American. Indian spiritual advisors and medicine men and women.

Our holistic approach encourages programs that empower the individual to take responsibility for change, whether the symptom is poverty, substance abuse, mental illness, homelessness, unemployment, domestic violence, or hunger. Our programs are designed to build a healthy community that supports recovery, role models, and peer support. We understand that individuals function in the context of interpersonal relationships, family, tribes, communities, and social institutions. Services aim at restoring overall balance, not only on targeting specific symptoms. In most cases, even though the "identified client" seeks help, the entire family and network of social relationships are addressed in the system of care. We believe that individual

change and social change are two sides of the same coin—transformation from different perspectives.

There is a marked contrast concerning the process of prevention between the views of Western psychologists and American Indians. Western treatment is often manualized, rigid, and terse in its route toward mental health. Native American ceremonies are intended to actually transform an individual's capacity and attitude, rather than just teach them how to adjust to certain circumstances.

The holistic system of care is the underlying wellness approach in almost every tribal nation of North America. By planning for the mind, body, heart and spirit to be addressed in a prevention program, we are allowing Native American clients a greater chance at successful participation. It is a common misunderstanding that most urban Indians do not benefit from therapeutic services designed around traditional modalities. In fact, just the opposite is true. Relocation and forced assimilation have created an urban Indian culture that not only desires traditional prevention and intervention services, but that can't survive without them.

Our cultural wellness approach to mental health emphasizes the importance of culture and spirituality for Native American programs. NAHC has provided statewide and national training to other urban Indian groups that want to begin the process of integrating traditional healing practices within their modern clinical therapies.

Culturally competent services for Native Americans must have food, drum, music, and community involvement. The importance of spirituality is paramount for Native Americans, especially as it relates to personal and community wellness. Also, programs for Native Americans must be family-focused. Here family is defined very differently compared to mainstream service providers——

"Each of our relations who have come before us and everyone who will come after."

Appendix

Documentation of the effectiveness of the *Holistic System of Care for Native Americans in an Urban Environment* as an evidence-based practice is contained in the following articles and reports by NAHC staff members and other professionals working with Native Americans on a national level.

Articles in peer-reviewed journals

Nebelkopf E & King J. Holistic System of Care for Native Americans in an Urban Environment. In: Nebelkopf E and Phillips M., eds., Morning Star Rising: Healing in Native American Communities, *Journal of Psychoactive Drugs*. 2003;35(1).

Nebelkopf E & Penagos M. Holistic Native Network: Integrated HIV/AIDS, Substance Abuse, and Mental Health Services for Native Americans in San Francisco. In Saylors K, Jim N, Plasencia AV & Smith D., eds., Faces of HIV/AIDS and Substance Abuse in Native American Communities*: Journal of Psychoactive Drug*s. 2005;37(3).

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In 2005, the Native American Health Center's *Holistic Native Network*, a HRSA-funded grant in its Special Projects of National Significance program was cited as a best practice on the IHS website. That project was based on the *Holistic System of Care for Native Americans in an Urban Environment.* The website location is:

http://www.ihs.gov/NonMedicalPrograms/HPDP/BPTR/index.cfm?module=BestPractices&option=Detail&BPTRSearchID=7695

Final Evaluation Reports

Final Report (HRSA- Special Projects of National Significance): Holistic Native Network, June 2007.
Final Report (CSAT- Expanded Adolescent Treatment): Generation Seven, December 2006.
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December 14, 2007

Mental Health Services Act (MHSA) Prevention and Early Intervention (PEI) Proposal: Needs Assessment & Program Planning for Latinos in South and East Alameda County

Section I: Organizational Background

The Hume Center is a non-profit, multi-service behavioral healthcare organization with service sites in Concord, Fremont, Hayward, Pittsburg and Pleasanton. The Hume Center has been providing culturally sensitive and linguistically appropriate services to the community for 14 years. Our staff is drawn from over ten cultures, offering impressive capabilities in 12 languages. Our current programs include:

Prevention Services are designed to solve stressful life problems before they can result in dysfunction and prolonged suffering. Our creative outreach and mental health consultation target under-served, high -risk populations to increase their chances for health and success in their lives and to reduce pressure on the overburdened social safety net.

Comprehensive Outpatient Services provide therapy to all age groups, from children to seniors.

Continuity of Care Services for seriously mentally ill persons promotes increased functioning and ability to reside in the community, thus prevent institutionalization by using intensive day treatment.

Neurobehavioral Assessment provides comprehensive psychological and neuropsychological evaluation services in a variety of languages for adults, children, and adolescents.

Behavioral Consulting Services improve the lives of consumers facing displacement by providing behavioral assessment, consultation and education to consumers, care providers and residential staff.

Training behavioral health professionals, interns and residents, to the highest standards of practice within a culture of support and mutual respect is fundamental to our mission as a training center.

Section II: Data Sources

The Hume Center drew upon its linguistic competence in Spanish to obtain information from local informants on local mental health needs, reflecting diverse cultural points of view. Most of the Latinos who participated in this project were recent immigrants. Many of the findings presented here may not apply to Latinos with higher levels of acculturation.

Data Sources

Surveys: Two surveys were prepared to capture information. One was designed for individuals (consumers, family members and un-served Latino community members), and the other for service providers and community organizations. The survey for individuals was prepared in both Spanish and English, but the Spanish version was preferred by all but one participant. The other survey was distributed in English only.

Personal Interviews: Interviews were conducted with individuals, service providers, and community organizations. Those interviewed included consumers, law enforcement personnel, social service personnel, and faith-based organization personnel.

Focus Group Discussions: Information was collected from two focus group discussions. One focus group consisted of Spanish speaking consumers, family members, and persons who had a need but had not accessed mental health services. The other focus group consisted of mental health providers.

Clinical Case Reviews: Clinical cases were reviewed to gather information on what has previously work in providing mental health services to Latinos, especially those with limited English proficiency, and what can be done differently to improve services. The cases reviewed included services being provided by a bilingual and bicultural clinician, a bilingual only clinician, and a non-Latina, English-only speaking clinician.

Section III: Recommendations

A. Most Common Problems

The most common problem identified by our informants was a difference in perception and unfamiliarity with mental health as conceptualized in mainstream culture. Many recently immigrated Latinos who are suffering from serious emotional distress are reluctant to identify their condition as a mental health issue. They are more likely to see it as a personal failing, physical illness, or even spiritual possession. Other barriers to accessing mental health services were identified as follows:

- Unawareness of services and/or the inability to access them, especially among those with limited English proficiency.
- Inability to utilize services because of a language barrier. The number of providers/clinicians who can provide services in Spanish is drastically disproportionate to the need.
- Lack of insurance, Medi-Cal, or funds to pay for the services.
- A fear that accessing services could result in deportation.
- Reluctance due to stigma and shame associated with mental health issues. A substantial majority is concerned about stigmatization, being labeled "crazy" by family and community members.
- Many of those in need believe that they will be misunderstood by service providers and judged wrongfully for cultural practices different than mainstream practices.

B. Local Community Mental Health Needs

1. Disparities in Accessing Mental Health Services

Latinos make up 28% of individuals living in Alameda County with an income level at 200% or more under the poverty level. Presently they constitute only 5% of those being served in the public behavioral health system. Why? Even though the small number of Latino and other providers are overwhelmed by current demands for services, there remains an even greater number of potential Latino clients in need who are reluctant to seek services for a number of cultural, linguistic, religious and stigma-based reasons.

2. Psycho-Social Impact of Trauma

Most Latinos who immigrate to the United States do so as an alternative to living in poverty in their home country. Many see the move to a new country as a last resort, and for political refugees it's often a matter of life or death. Some new immigrants are even forced to leave their children under the care of someone else until they can earn enough money to go home or send for them. As a result of the above, many experience a loss of family and community, which manifests as depression, anxiety disorders, adjustment disorders, and acculturation problems. Not being able to communicate in the dominant language further contributes to the feeling of being an outsider. Disconnection from the community-at-large may lead to antisocial behavior and problems with the law.

3. Needs of At-Risk Children, Youth and Young Adults

The most prevalent condition identified as putting children at risk was the financial situation that forces both parents to work long hours and leave their children unsupervised, supervised by older siblings, or supervised by other family members. Lack of parental involvement in schools was the second prevalent condition identified. The difference in the level of acculturation of the parents and the children was identified as a contributing factor in higher conflict between parents and their children. Children of immigrant parents are forced to simultaneously live in two cultures: the culture of their parents and the mainstream culture. This often results in a sense of belonging to neither culture, and opens the door to seek a sense of belonging elsewhere such as in gangs.

4. Stigma and Discrimination.

The stigma associated with having a mental health issue is a significant barrier to accessing mental health services. In one particular example, the parents of a suicidal teenager preferred to have their daughter declared as being possessed rather than being labeled with a mental health condition. When the priest from whom they sought an exorcism referred them to a "doctor," the family left the church, angry with the priest and never returned. Mental health services are seen strictly as services for the severely mentally ill. Many believe that if they seek mental health services at any level, they will be seen by others as being severely mentally ill.

5. Suicide Risk

Suicide is considered a mortal sin by the Roman Catholic Church. The majority of Latinos identify themselves as Catholics. Suicidal ideations are generally not discussed because of the belief that suicide is a mortal sin. On the other hand, the belief that suicide victims will go to hell is often disclosed in suicide risk assessments as the reason the person will not carry out any suicidal thoughts. One consumer with a history of depression disclosed that she discontinued counseling services after being asked if she had suicidal ideations because she was deeply offended by the question. The other common reason disclosed by many Latinas for not carrying out suicidal ideations is the impact it would have on their children. Data on the actual suicide rates among Latinos in the south and east areas of Alameda County was not collected.

C. Priority Populations

Given that Latinos are a key under-served cultural population overall, we propose the following priority-ranking of needy populations within the community:

1) Children and Youth at Risk of Juvenile Justice Involvement
2) Children/Youth at Risk for School Failure
3) Trauma-Exposed Children/Youth
4) Children/Youth in Stressed Families
5) Individuals Experiencing Onset of Serious Psychiatric Illness

D. *Desired Outcomes*

As a broad recommendation, we propose to engage in strategies which re-frame mental health and behavioral health care from a pathological perspective to a strength-based, normative, developmental assets focus. Within that framework, we propose:

1. **Developing and Providing Community-based Outreach Programs and Educational Workshops on Mental Health Issues.** Educational workshops are needed that explain common responses to life stressors as conditions that can be helped through mental health services. There needs to be more public service announcements, materials and discussions through Spanish language media to normalize and reduce the stigma of accessing mental health services.
2. **Strengthening the Existing Support Structures in the Community.** Culturally-competent experts will provide mental health consultation that supports the existing network of immediate and extended family, the church, *curanderos* (faith healers) and medical professionals, allowing for early case finding and intervention.
3. **Providing School- and Community-based Activities and Workshops.** Behavioral health education, youth and parental support workshops, are needed in non-stigmatized sites convenient to the community.
4. **Developing After-School Programs to Reduce At-Risk Conditions/Behavior.**
5. **Developing Programs to Increase Parental Participation at Children's Schools**
6. **Developing and Promoting Cross-age Mentorships.** Trained and supervised cross-age peer mentorships involving youth who are culturally-matched are needed to model positive behaviors and strengthen developmental assets that will help vulnerable youth surmount the challenges of growing up in a culturally-bifurcated social environment.

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December 14, 2007

MHSA Prevention and Early Intervention (PEI) Proposal for Needs Assessment & Program Planning for South Asians

Section I: Organizational Background

The Hume Center is a non-profit, multi-service behavioral healthcare organization with service sites in Concord, Fremont, Hayward, Pittsburg and Pleasanton. The Hume Center has been providing culturally sensitive and linguistically appropriate services to the community for 14 years. Our staff is drawn from different cultures (Afghan, East Indian, Pakistani, and other South Asian; Chinese, Taiwanese, and other East Asian; African, European, and Latino), reflecting diversity in ethnicity, socio-economic status, sexual orientation, gender, offering impressive capabilities in 12 languages. Our current programs include:

Prevention Services are designed to solve stressful life problems before they can result in dysfunction and prolonged suffering. Our creative outreach and behavioral health consultation target under-served, high -risk populations to increase their chances for health and success in their lives and to reduce pressure on the overburdened social safety net.

Comprehensive Outpatient Services provide psychotherapy to all age groups, from children to seniors. We work with families, couples and individuals in partnership with other agencies in the community to assist improved individual and family social functioning.

Continuity of Care Services for seriously mentally ill persons promotes increased functioning and ability to reside in the community, thus prevent institutionalization by using intensive day treatment.

Neurobehavioral Assessment provides comprehensive psychological and neuropsychological evaluation services in a variety of languages for adults, children, and adolescents.

Behavioral Consulting Services improve the lives of consumers facing displacement by providing behavioral assessment, consultation and education to consumers, care providers and residential staff.

Training behavioral health professionals, interns and residents, to the highest standards of practice within a culture of support and mutual respect is fundamental to our mission as a training center.

The Hume Center specializes in prevention and early intervention with particular skill and experience in addressing cultural diversity. Hume Center's clients are a microcosm of Alameda County's multicultural communities, including African-Americans, Asians, Caucasians, Latinos, and Middle Easterners. We recognize that all cultures have the ingredients necessary to support healthy human development. The personal and professional experiences of the Hume Center's founders and its staff have yielded a rich understanding and appreciation for the gifts of each culture and the challenge of external barriers to successful community living.

Section II: Data Sources

The Hume Center drew upon its linguistic competence in many South Asian languages to obtain extensive information from key local informants on local behavioral health needs, reflecting diverse cultural points of view. These included: Dr. Meji Singh, a premier South Asian expert in preventive psychiatry; Dr. Nitu Hans, an East Indian neuropsychologist and researcher; Dr. Khalil Rahmany, a renowned Afghani psychologist; Dr. Razia Iqbal, an Afghan expert in domestic violence; and Ms. Hafasah Mojaddidi, an Afghan youth community organizer. Data sources included:

(1) Clinical Case Reviews. Four key South Asian physicians and psychologists in Alameda County who have extensive experience in working clinically with local South Asian populations were interviewed and provided perspectives on clinical presentations and barriers to service.

(2) Published Research. A literature review was conducted based on documentation contained in four recent doctoral dissertations on the behavioral health needs of South Asians.

(3) Surveys, Phone Interviews, and Focus Group Discussions. A survey was prepared to capture information from individual interviews and group discussions. Ten individual interviews were conducted, including representatives of social service organizations, faith-based entities, and consumers and family members. Four focus groups took place that included South Asian high school students, professional providers, teachers, and community leaders.

Section III: Recommendations

A. Most Common Problems

According to our informants, the most common presenting problems in the South Asian community are, in order: depression, anxiety, domestic violence (including spousal and child abuse), adjustment disorder, oppositional and anti-social behaviors, family dysfunction, and developmental disabilities. More generally, our informants also cited the following problems:

- Inability to utilize service because of language barriers, unawareness of services (especially among recent immigrants), and/or the ability to access them.
- Reluctance to seek behavioral health services due to the stigma and shame associated with psychological problems. Some of those in need are concerned about confidentiality and fear of being misunderstood by providers if they seek behavioral health services.
- Many of those in need believe that services provided by agencies outside of their particular communities are not appropriate for them and will not be sensitive to their particular needs.
- Difficulty overcoming major acculturation and generational conflicts.

B. Local Community Mental Health Needs

1. Disparities in Accessing Mental Health Services

All Asians (including South Asians) make up 21 % of the population of Alameda County, presently they constitute only 2.5% of those being served in the public behavioral health system. Why? There are insufficient providers for South Asian service needs. Those in need are uninformed about available services, or unable to navigate the system.

2. Psycho-Social Impact of Trauma

Many South Asians are traumatized by experience of war or violence in their native countries which has resulted for many in loss of parents and other family members. Immigration has many unanticipated traumatic results i.e., a professional person such as medical doctor, professor or engineer might need to work as a cab driver or gas station attendant. Domestic violence and child abuse and neglect may result from severe stresses relating to inability to adjust to new immigrant status or economic distress.

3. Needs of At-Risk Children, Youth and Young Adults

Differential rates of acculturation between immigrant parents and their children definitely tend to aggravate the traditional "generation gap" common even to mainstream parents and children. These are multi-stressed families. Both parents have to work, leaving children on their own, with older ones caring for their younger siblings. Traditional, strict parenting practices are experienced by children who see their mainstream peers supervised differently by their parents. Parental pressures on children, particularly for academic achievement, are liable to backfire on those who cannot live up to the expectations of a "model minority." Those who don't fit the stereotype are liable not only to struggle academically but experience shame and rejection. Many start manifesting problematic behaviors (depression, oppositional/defiant and aggression to others) that lead to low self-esteem resulting in interpersonal and social difficulties and thus into isolation or lead to truancy and suspension from school, and drift into gang activity as an "alternative family."

4. Stigma and Discrimination.

Stigma is a very common issue in the South Asian community. Behavior and attitudes are not conceptualized in mental health terms and from a mental health perspective. Mental health is not seen as a continuum of issues but commonly is perceived to only define a person as "possessed" or "crazy." Denial is common, and silence is the normative response to the risk of being the "talk of the town." When a person who is suffering cries out for help, the family or community often acts to silence that person, considering the honor of the family and community as paramount values. South Asians have also suffered discrimination and even violence in the wake of the "War on Terror." Locally, specific acts of brutal violence have occurred, making a huge and lasting impression on this population.

5. Suicide Risk

There is insufficient information to assess the risk of suicide in the local South Asian community. Felony assault or homicide is more in common in the community. But stressors, often resulting from problems discussed above, may on occasion lead to violent injury and occasional death in these families.

C. Priority Populations

South Asians are the key under-served cultural population overall. We propose the following priority-ranking of needy sub-populations within this community:

1) Trauma-Exposed Children/Youth
2) Children/Youth in Stressed Families
3) Children/Youth at Risk for School Failure
4) Children and Youth at Risk of Juvenile Justice Involvement
5) Individuals Experiencing Onset of Serious Psychiatric Illness

D. Desired Outcomes

As a broad recommendation, we propose a strategy of re-framing behavioral health care from a pathological perspective to a strength-based, normative, developmental assets focus. Within that framework, we propose:

1. Developing and Providing Community-based Outreach Programs and Educational Workshops on Mental Health Issues. Educational workshops are needed that explain common responses to life stressors as conditions that can be helped through mental health services. There needs to be more public service announcements, materials and discussions through South Asian language media to normalize and reduce the stigma of accessing mental health services.

2. Strengthening the Existing Support Structures in the Community. Culturally-competent experts will provide mental health consultation that supports the existing professional, paraprofessional, and non-professional network (attorneys, physicians, law enforcement, social workers, teachers, faith-based organizations, community leaders/centers, peer groups, parents), allowing for early case finding and intervention.

3. Developing Planning or Orientation Venues for Major Life Transitions and Crises. Natural support groups that can be peer-facilitated with professional assistance are needed to help with transitions such as the birth of a child or a child starting school and also with life crises like the threat of deportation or the death of a family member.

4. Developing and Promoting Cross-age Mentorships. Trained and supervised cross-age peer mentorships involving youth who are culturally-matched are needed to model positive behaviors and strengthen developmental assets that will help vulnerable youth surmount the challenges of growing up in a culturally-bifurcated social environment.

5. Providing School- and Community-based Activities and Workshops. Education and support workshops, where youth and parents meet, both separately and together, are needed in non-stigmatized sites in private homes, schools, and elsewhere in the community where information is communicated and shared by youth-respected providers about drugs and alcohol, non-violent problem solving, resistance and resilience to negative peer influence, etc.

The Hume Center's Needs Assessment and Proposed Program Strategies for PEI across Alameda County

Section I. Description

The Hume Center, formally known as Portia Bell Hume Behavioral Health and Training center, is a non-profit, multi-service behavioral healthcare organization with service sites in Concord, Fremont, Hayward, Pittsburg and Pleasanton. The Hume Center has been providing culturally sensitive and linguistically appropriate services to the community for 14 years. Our staff is drawn from over ten cultures, offering impressive capabilities in 12 languages. Our current programs include:

Prevention Services are designed to solve stressful life problems before they can result in dysfunction and prolonged suffering. Our creative outreach and behavioral health consultations target under-served, high -risk populations to increase their chances for health and success in their lives and to reduce pressure on the overburdened social safety net.
Comprehensive Outpatient Services provide therapy to clients of all age groups in numerous languages.
Continuity of Care Services for seriously mentally ill persons promotes increased functioning and ability to reside in the community without institutionalization using intensive day treatment.
Neurobehavioral Assessment provides comprehensive psychological and neuro-psychological evaluation services in a variety of languages for adults, children, and adolescents.
Behavioral Consulting Services improve the lives of consumers facing displacement by providing behavioral assessment and follow-up services, in various languages, to consumers, as well as consultation and education to care providers and residential staff.
Training behavioral health professionals, interns and residents, to the highest standards of practice within a culture of support and mutual respect is fundamental to our mission as a training center.

Section II. Data Sources

Caplan, G. (1964). *Principles of Preventive Psychiatry*. New York: Basic Books. (Gerald Caplan. M.D. was the foremost proponent of community psychiatry).
Caplan, G. (1970). *The Theory and Practice of Mental Health Consultation.* New York: Basic Books.
Sikand, J. (2003). *Mental Health Consultation as an Interactional Process* (Joty Sikand, Psy.D. is the President of the Hume Center, and a student of Dr. Singh).
Singh, R. K. J., Tarnover, W., & Chen, R. (1971). Community *Mental Health Consultation and Crisis Intervention*, (Dr. Meji Singh is Founding President of the Hume Center, Chief Psychologist, and Director of Training. Professor, Dept of Education, University of California, Berkeley 1990-2007. Assistant Director Center for Training in community Psychiatry, Berkeley 1966-80. He was a student of Dr. Caplan).
Singh, R.K. J., (1970b). Implementation of a Program of C*ommunity Mental Health Consultation.* Unpublished manuscript.
Singh, R.K. J., Bio-statistical Study of Behavioral Consultation Program

Section III. Recommendations

Most Common Problems: Individuals in crisis or stressful life transition typically have that experience outside of context of behavioral health resources. By the time many people come to mental health services, typically with a formal referral, they are already in crisis or an acute condition, and the opportunity for preventative action and intervention has been lost. The "first responders" are teachers, clergy, social workers, probation officers, physicians, lawyers, or even a trusted relative. Though typically well-intentioned, these individuals often lack the skills to identify problems and stabilize individuals in crisis until they can be referred (if appropriate) to professional care. Currently, mental health consultation services that could assist these individuals are only minimally or not all available in the community.
Proposed Approach: As part of its mission, the Hume Center from inception has sought to bridge gaps in mental health care by responding to the needs of underserved populations. We believe that prevention and early intervention are essential for an improved continuum of care in Alameda

County, and that services can be supplied most effectively and cost-efficiently by using a Community Mental Health Consultation (CMHC) model. CMHC utilizes professionals trained in psychology who interact within the existing support structures of the community. A large percentage of the time, with some guidance from a mental health consultant, service professionals and even non-professional caretakers like family members can successfully assist troubled individuals through a crisis or stressful transition before they reach an acute phase. They may also, properly supported, identify at-risk individuals before they reach an acute phase, support them in crisis resolution, and even increase their mental health and functionality. Under the CMHC model, professionals in human services (e.g., teachers, social work case managers, probation officers, physicians, lawyers) and caretakers (e.g., parents, clergy) referred to as "consultees" are helped to understand the psychological meaning of changes in the behavior of individuals in their charge ("clients"). This knowledge actually empowers them to achieve their own particular work objectives with those clients or to provide effective support with those family members/friends. CMHC makes it possible for these consultees to serve as an effective first line of intervention, working with clients facing immediate, pressing problems. They are more likely, moreover, to be able to reach and help clients in the midst of life crises but not after acting out or destructive behavior has made consequences difficult to repair. Key to the operation and success of the CMHC model are professionals ("consultants") trained in psychology who understand intra-psychic, inter-personal and organizational dynamics, but apply that knowledge in a non-traditional manner. While it is crucial that the consultant understands the interactional dynamics between him/herself and the consultee, the focus is maintained on the client. Information gathering and interaction with the consultee is managed in such a way that the consultee is constantly "informed" that he/she is in charge of resolution. The consultant directs the focus to maximizing the consultee's knowledge of the client. As a by-product, the consultee is enabled to discover solutions to his/her issues with a client or the client's issues. At the same time, the consultee learns to trust that in the event of acute mental health need, he/she will be able to make an appropriate and skillful intervention with a client in need. In the model, a consultant helps the consultee to develop the skill of "empathetic exploration," in which the focus is on getting to know the client rather than solving the presenting problem. Hopeful exploration brings out information about the client in a respectful way which often contributes to positive change. The process creates an expanded perception of the client and results in an objective understanding of her/him, allowing the consultee to begin (or resume) working effectively with the client and providing proper support. In the training process, the consultant uses verbal and nonverbal communication to correct the consultee's distortions and inadequate perceptions of the client and/or work situation through the interactional process. Another important skill required in this consultation method is the consultant's ability to identify "theme interference" which results in psychological blind-spots, limiting the consultee's ability to understand and assist those in his/her care. For the consultee, a potentially important part of the process is the role-modeling in the skill of emotional management and problem solving. This form of learning has been found to be far more useful and lasting than that learned in a more didactic approach. People learn the "routine" of dealing with life crises and are enabled to better help others. The model nonetheless recognizes if and when professional mental health intervention is necessary, and then there is appropriate referral to skilled, culturally-sensitive care.

B. Local Community Mental Health Needs

In program evaluation studies of community mental health consultation programs as referenced above in the Section II, "Data Sources," and in the our recently-prepared reports to the MHSA on the Latino community and the South Asian Community has noted the following needs that implementation of a CMHC model of care can address.

1. ***Disparities in Accessing Mental Health Services***. There are not enough mental health professionals to meet the needs in communities.
2. ***Psycho-Social Impact of Trauma***. An individual suffering from trauma may go to a trusted caretaker or respected professional service person for help, but that trust agent may be unequipped to handle that individual at his/her level of acute need.

3. ***Needs of At-Risk Children, Youth and Young Adults***. These individuals usually lack awareness to self-diagnose, peer influence may actually dissuade them from seeking help, and/or they may be resistant to accepting help from those (e.g. parents and other adults) who are in a position to help or link to professional assistance.
4. ***Stigma and Discrimination***. Mental health may not have been reframed in ways acceptable to the norms of the community and particular cultures, thus resulting in embarrassment, stigma and discrimination.
5. ***Suicide Risk***. Like traumatized individuals, but even more acutely, those at risk for suicide need immediate sensitive and appropriate intervention as a life and death matter. Unfortunately, many are hopeless and are unable to seek help and/or, when they do access help, professionals and caregivers lack the knowledge and often the ability to manage their own emotions when interacting with individuals at risk for suicide, thus exacerbating the risk.

C. Priority Populations

Hume sees under-served cultural populations as the umbrella or catchments for other listed priority populations, specifically: individuals experiencing onset of serious psychiatric illness, children/youth in stressed families, trauma exposed, and children/youth at risk for school failure, and children and youth at risk of juvenile justice involvement. Self or socially destructive functioning mark the ways that behavior may go. Guidance and supervision by people who are skilled in the methods of mental health consultation or those "graduates" of the method, who have learned to deal with psychological process and issues under its guidance will be required as part of the solution in addressing any and all of the priority populations.

D. Desired Outcomes

As a broad recommendation, we propose to engage in strategies which re-frame mental health and behavioral health care from a pathological perspective to a strength-based, normative, developmental assets focus. Within that framework, we propose:

- Increase the numbers in professionals trained in the consultation method and direct treatment with linguistic skills appropriate to the underserved populations.
- Identify, join and support the existing asset development or support structures as defined by the various sub-communities of Alameda County and ally with professionals, paraprofessional and caretakers there utilizing trained community mental health consultants who go in as learners and collaborators to assist these persons to better function as they assist those in their care to improved problem solving and social functioning.
- Optimize cultural-competence in deployment of mental health professionals, who will provide mental health consultation that supports the existing pro-social structure of the under-served populations allowing for early case finding and intervention.
- Support the linkage and delivery of service to identify in need, including acute cases and in the case of waiting lists for services, consultation method can be used to handle temporary group and individual support activities. Insure that crisis intervention and follow-up services are available to a person who is challenged with new life crises.
- Support the concept of "prevention through multiplication" by training and ongoing consultation to consumers/peers and family members utilizing the consultation method in a support and training groups, (ex. In Genesey County, Flint, Michigan, Dr. Singh had started a 19 mother parent-support group that led to the empowerment of those mothers to facilitate additional parent supports groups with ongoing professional consultation, resulting in over 100 groups taking place across county.)

Mental Health Services Act
Prevention & Early Intervention

COMMUNITY REPORT EXECUTIVE SUMMARY COVERSHEET

Instructions:
1. Please use this form as a cover to any report you want to submit for review by the PEI Planning Panels.
2. Email this completed form and an electronic version of your report (Word document or PDF) to mhsa@acbhcs.org no later than December 14, 2007.

Organization* (if applicable): Alameda County Children's Advisory Committee
Contact Person: Ed Walker, STARS Community Services
Address: 545 Estudillo Avenue, San Leandro, CA 94577
Phone No./ Email address: (510) 352-9200 | ewalker@starsinc.com

Please attach a list of all groups and organizations that contributed to this report.

What age group does your organization serve or represent?

☑ Children & Youth (0-18)
☑ Transition Age Youth (14-25)
❒ Adults (18-59)
❒ Older Adults (60+)

Under each category, choose the item your report PRIMARILY addresses:

Key Community Mental Health Needs

❒ Disparities in Access to Mental Health Services
☑ Psycho-Social Impact of Trauma
☑ At-Risk Children, Youth and Young Adult Populations
❒ Stigma and Discrimination
❒ Suicide Risk

Priority Populations

❒ Underserved Cultural Populations
❒ Individuals Experiencing Onset of Serious Psychiatric Illness
☑ Children/Youth in Stressed Families
☑ Trauma-Exposed
☑ Children/Youth at Risk for School Failure
☑ Children and Youth at Risk of Juvenile Justice Involvement

For more detailed explanations of the terms above, please review the PEI Program & Expenditure Guidelines available at http://www.dmh.ca.gov/Prop_63/MHSA/Prevention_and_Early_Intervention/default.asp

ALAMEDA COUNTY CHILDREN'S ADVISORY COMMITTEE
PREVENTION AND EARLY INTERVENTION RECOMMENDATIONS
EXECUTIVE SUMMARY

SECTION I - ORGANIZATIONAL BACKGROUND:

The Children's Advisory Committee (CAC) is a sub-committee of the Mental Health Board, and as such convenes on a monthly basis. The CAC consists of providers of Mental Health Services delivered by both county operated sites and Community Based Organizations. As providers of mental health services the CAC membership understands the importance of Prevention and Early Intervention Services. These services provide a mechanism to help prevent the escalation of mental health problems, thereby, allowing children and youth to mature in a developmentally appropriate manner.

Based on CAC's belief in the importance of prevention and early Intervention, the CAC convened a work group of its membership to develop and submit a strategy for use of MHSA, Prevention and Early Intervention (PEI) funding. The CAC process for developing its strategy involved convening and facilitating two large brainstorming sessions with the CAC membership. In total, over 50 people participated in these brainstorming sessions. As an outcome of the large group discussions, CAC identified a small workgroup to take the feedback from the brainstorming sessions and frame the CAC priority recommendations and strategies for PEI. CAC has worked with its member organizations and other county stakeholders, namely, Alameda County School Health Services Coalition, the HUSKEY Committee and Alameda County Early Childhood Mental Health Planning Committee to envision what a comprehensive mental health care continuum for children and youth in Alameda County would comprise. (Please see Attachment 1: CAC Mailing List.)

Based on input from CAC members and the outcome from our collaborative discussions, the CAC recommends the implementation of three strategies to address the unmet prevention and early intervention needs of At Risk Children and Youth among the following priority populations:

- Children/Youth in Stressed Families
- Trauma-Exposed Youth, Children/Youth at Risk for School Failure
- Children and Youth at Risk of Juvenile Justice

Specifically, CAC proposes the implementation of evidence based strategies in the schools and in primary care settings that will improve screening, assessment, and linkages to services for elementary school age children who experience trauma.

SECTION II - DATA SOURCES:

CAC supporting data for the PEI recommendations was derived from primarily from three sources: 1) Published research on childhood trauma and evidence based practices for prevention and early intervention to reduce mental illness and related poor health outcomes; 2) CAC brainstorming sessions with member child advocates, youth advocates, and behavioral health providers; and 3) Strategic planning discussion with child, youth, and family centered organizations that represent unique strands of the child and youth population in Alameda County. Specifically, the data and information represent:

- **Published research on childhood trauma:** Key research data is derived from three sources: 1) the National Child Traumatic Stress Network (NCTSN), a national resource for developing and disseminating evidence-based interventions, trauma-informed services, and public and professional education;[1] 2) studies on trauma among youth in the juvenile justice system; and 3) mental health intervention strategies for schoolchildren exposed to violence. Traumatized youth can be from any background, but those who experience significant early life trauma often come from environments in which they are subject to more stress and have fewer resources to help them develop than children who do not suffer early life trauma. Traumatic experiences can include not only physical or sexual abuse or assault but also serious accidents, illnesses, disasters, and the loss of important relationships or caregivers. When

[1]NCTSN comprises 70 member centers-45 current grantees and 25 previous grantees-and is funded by the Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, US Department of Health and Human Services through a congressional initiative: the Donald J. Cohen National Child Traumatic Stress Initiative.

trauma occurs early in childhood, critical aspects of brain and personality development may be disrupted.[2], [3] Several studies have found that the majority of children exposed to violence, defined as personally witnessing or directly experiencing a violent event, display symptoms of posttraumatic stress disorder (PTSD).[4] Exposure to violence is associated with depression[5] and behavioral problems. [6],[7],[8] Exposure to violence also may interfere with the important developmental milestones of childhood and adolescence. Interventions that address the needs of children who are experiencing a range of symptoms after witnessing or experiencing violence are needed.

- **CAC brainstorming sessions:** Over 50 individuals including CAC members, community and school-based mental health providers, and key policymakers in Alameda County participated in planning discussion between March and October of 2007. These meetings provided a forum for discussing the mental health needs of children and families within the context of meeting the objectives of the MHSA, PEI funding. Participants discussed the prioritization of defined needs and myriad strategies and solutions. From this group process a seven member workgroup was formed and charged with taking the large group input and formulating a framework for the CAC PEI strategy.
- **Strategic planning discussions:** The CAC workgroup engaged in strategic discussions with other key stakeholder groups, e.g., Alameda County School Health Services Coalition, HUSKEY, and Alameda County Early Childhood Mental Health Planning Committee to flesh-out a children and youth strategy. This CAC summary reflects the best practices review, feedback from planning discussions, and deliberation by the workgroup.

SECTION III - RECOMMENDATIONS:

Children exposed to traumatic events exhibit a wide range of symptoms, presenting with not just internalizing problems, such as depression or anxiety, but also externalizing problems like aggression, conduct problems, and oppositional or defiant behavior.[9] Early detection, assessment, and links with treatment and supports can prevent mental health problems from worsening. Without intervention, child and adolescent disorders frequently continue into adulthood.

Child traumatic stress occurs when children and adolescents are exposed to traumatic events or situations, and this exposure overwhelms their ability to cope with what they have experienced.[10] Large numbers of US children experience violence, and an even greater number may experience symptoms of distress after personally witnessing violence directed at others. Traumatic events can include physical abuse, sexual abuse, domestic violence, community violence, and/or disasters.[11] Although estimates vary, it is believed that the prevalence of trauma among children and youth in the general population is substantial. In one nationally representative survey of 9–16 year olds, 25% reported experiencing at least one traumatic event, 6% in the past 3 months.[12] The National Center on Child Abuse and Neglect reports that more than 2% of all children are victims of maltreatment, 13% are victims of neglect, and 11% are victims of physical, sexual, or emotional abuse.[13]

---

[2] Ford, J.D. (2002). Traumatic victimization in childhood and persistent problems with oppositional-defiance. *J Trauma, Maltreatment, and Aggression, 11,* 25-58.

[3] Ford, J. D. (2005). Treatment implications of altered neurobiology, affect regulation and information processing following child maltreatment. *Psychiatr Ann, 35,* 410-419.

[4] Cuffe SP, Addy CL, Garrison CZ, et al. Prevalence of PTSD in a community sample of older adolescents. *J Am Acad Child Adolesc Psychiatry.* 1998;37:147-154. Horowitz K, Weine S, Jekel J. PTSD symptoms in urban adolescent girls: compounded community trauma. *J Am Acad Child Adolesc Psychiatry.* 1995;34:1353-1361.

[5] Kliewer W, Lepore SJ, Oskin D, Johnson PD. The role of social and cognitive processes in childrens adjustment to community violence. *J Consult Clin Psychol.* 1998;66:199-209.

[6] Fitzpatrick KM, Boldizar JP. The prevalence and consequences of exposure to violence among African-American youth. *J Am Acad Child Adolesc Psychiatry.* 1993;32:424-430.

[7] Martinez P, Richters JE. The NIMH Community Violence Project, II: children's distress symptoms associated with violence exposure. *Psychiatry.* 1993;56:22-35.

[8] Farrell AD, Bruce SE. Impact of exposure to community violence on violent behavior and emotional distress among urban adolescents. *J Clin Child Psychol.* 1997;26:2-14.

[9] Ibid.

[10] Julian D. Ford, PhD, Department of Psychiatry, University of Connecticut School of Medicine

[11] John F. Chapman, PsyD, State of Connecticut Judicial Branch, Court Support Services Division

[12] Josephine Hawke, PhD, Department of Psychiatry, University of Connecticut School of Medicine

[13] John F. Chapman, PsyD, State of Connecticut Judicial Branch, Court Support Services Division

While some children bounce back after adversity, traumatic experiences can result in a significant disruption of child or adolescent development and have profound long-term consequences. Repeated exposure to traumatic events can affect the child's brain and nervous system and increase the risk of low academic performance, engagement in high-risk behaviors, and difficulties in peer and family relationships. Traumatic stress can cause increased use of health and mental health services and increased involvement with the child welfare and juvenile justice systems.

CAC PEI Strategy

CAC recommends universal screening, assessment, and referral for trauma in elementary school age children at schools and in primary care settings. Evidenced based practices would be used to implement universal screening, comprehensive assessment, and linkage of children to appropriate services who are at risk of developing PTSD after a traumatic accident, injury or exposure.[14] Based on the information gathered in the trauma screening, it is expected that there will be elementary age school children that will need trauma specific early intervention services. These services should be short term (up to 12 months) and designed to help prevent the escalation of mental health issues that result from trauma exposure.

Implementation of Trauma Focused Evidenced Based Practices (EBP)

In addition to universal screening tools, the following EBPs are recommended for use in this care system:

- **Universal screening tools** comprised of one or more of the following: *The Child Trauma Screening Questionnaire, the Children's Impact of Events Scale*, the Anxiety Disorder Interview Schedule for DSM IV (Child Version), or the Clinician-administered *PTSD Scale for Children and Adolescents*
- **Cognitive – Behavioral Intervention for Trauma in School (CBITS):** A skills-based, group intervention aimed at relieving symptoms of PTSD, depression, and anxiety among children exposed to trauma, and teaching them resiliency and coping skills.
- **Trauma Focused Cognitive Behavioral Therapy (TFCBT):** A SAMHSA model program designed to help children, youth, and their parents overcome the negative effects of traumatic life events.

Service implementation should be based on school site selection following an analysis of data available form Public Health, BHCS, SSA, local law jurisdictions, Emergency Medical Services, and all other applicable programs where exposure to trauma can be identified. Linkages should be extended to community programs (Family Law Center, Another Road to Safety-ARS, etc.) that work with trauma exposed youth so that referrals can be expedited when exposed youth live in an area with a PEI Trauma Focused Program. A thorough review of existing trauma services should be conducted and as indicated, additional training should be provided to programs (school and community based) to build their capacity to recognize the early signs of trauma as an adjunct to standardized screening tools, and to enhance their utilization of the recommended EBP. Primary care settings will be identified and/or connections to primary care settings to participate in this strategy will be developed.

Anticipated Outcomes

EBP STRATEGY	INTENDED OUTCOMES
Cognitive Behavioral Intervention for Trauma in School (CBITS)	• Improvements in behaviors related to protective factors • Reductions in behaviors related to risk factors • Lower post-traumatic stress and depressive symptoms • Lower psychosocial dysfunction
Trauma Focused Cognitive Behavioral Therapy (TFCBT)	• Reduction in behavior problems • Reduction in PTSD symptoms, i.e. depression, self-blame, defiant and oppositional behaviors, anxiety • Improved social competence (maintained for one year) • Improved adaptive skills for dealing with stress; decreased anxiety for thinking or talking about the event; enhanced accurate/helpful cognitions and personal safety skills and parental support

[14] These tools are identified by the California State Department of Mental Health in the MHSA Resource Materials Document.

CHILDREN'S ADVISORY COMMITTEE (CAC)
MHSA PREVENTION EARLY INTERVENTION WORKGROUP

Banks, Shannon
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Herrera, Joanna
Hilley, Lisa
Hunt, Linda
Jacobson, Kathie
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Salas-Patten, Crystal
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Zaragoza, Raquel

Mental Health Services Act
Prevention & Early Intervention

COMMUNITY REPORT EXECUTIVE SUMMARY COVERSHEET

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2. Email this completed form and an electronic version of your report (Word document or PDF) to mhsa@acbhcs.org no later than December 14, 2007.

Organization* (if applicable) Alameda County Early Childhood Mental Health Planning Committee
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**Please attach a list of all groups and organizations that contributed to this report.*

What age group does your organization serve or represent?

X Children & Youth (0-18) ❒ Transition Age Youth (14-25) ❒ Adults (18-59) ❒ Older Adults (60)

Under each category, choose the item your report PRIMARILY addresses:

Key Community Mental Health Needs

X Disparities in Access to Mental Health Services
❒ Psycho-Social Impact of Trauma
X At-Risk Children, Youth and Young Adult Populations
❒ Stigma and Discrimination
❒ Suicide Risk

Priority Populations

X Underserved Cultural Populations
❒ Individuals Experiencing Onset of Serious Psychiatric Illness
X Children/Youth in Stressed Families
❒ Trauma-Exposed
X Children/Youth at Risk for School Failure
Children and Youth at Risk of Juvenile Justice Involvement

For more detailed explanations of the terms above, please review the PEI Program & Expenditure Guidelines available at http://www.dmh.ca.gov/Prop_63/MHSA/Prevention_and_Early_Intervention/default.asp

Recommended Strategies for Children 0-5

SECTION I - ORGANIZATIONAL BACKGROUND:

The Early Childhood community has been working collaboratively for more than a decade to improve and expand services for young children zero to five in Alameda County in order to ensure social emotional well being for all of our counties youngest residents. The groups working on these efforts include: the Early Childhood Mental Health Systems Development Group, Safe Passages and the EPSDT 0-5 Provider group. The Alameda County Early Childhood Mental Health Planning Committee brought these groups together to decide on priorities for MHSA PEI. The group consists of providers from a variety of county, public and community-based organizations and child care planning council staff (see Appendix 1 for a complete list). The members of the committee all represent agencies that provide mental health and family support services to a diverse group of children and their families throughout Alameda County These children and their families include immigrant families, families with disabilities, families with a mentally ill family member, as well as a variety of other challenges that keep families isolated. Although the committee recognizes the importance of providing integrated services to children throughout the developmental continuum to adulthood, we also believe that the earlier one can support resilience in young children and families, the better for long term outcomes.

SECTION II - DATA SOURCES:

The findings and recommendations presented in the paper came primarily from three sources: 1) research, 2) focus group data, and 3) knowledge and expertise from the service providers on the committee.

1) Research has shown that experiences for early childhood set the foundation for a child's social and emotional health, including evidence that experiences in the first three years of life can alter brain development. Research has also identified a set of risk factors, or stressors, that increase the odds that children will struggle with later social, emotional and cognitive difficulties. In addition, research has proven that there are interventions that can improve the social-emotional health of a child and are cost-effective by reducing the need for more costly interventions later in life. Specific research is cited throughout the attached paper.

2) In January 2007, First 5 Alameda County, Every Child Counts spearheaded a county-wide planning process, in partnership with the County Health Care Services Agency, the Regional Center of the East Bay and various Alameda County cities, school districts and county agencies. The goal of the planning effort was to enhance and strengthen screening, triage and referral, assessment and treatment services for children 0-5 at risk of developmental and/or social-emotional delays. A series of meetings and focus groups were held during the planning process with input from more than 35 organizations. The findings from these focus groups were incorporated into the attached report. A full list of participants in those groups can be provided upon request.

3) Approximately 30 experts, representing more than 15 organizations in Alameda County sat on the Alameda County Early Childhood Mental Health Planning Committee to develop the set of recommendations in this report. All of the participants are experts, with many of the participants having more than 20 years of experience providing services to families in Alameda County. The knowledge, experience, and collaboration among these providers informed the recommendations in the report.

SECTION III - RECOMMENDATIONS:

The Alameda County Early Childhood Mental Health Planning Committee, is recommending that a set of services be funded through the Mental Health Services Act Prevention and Early Intervention Program (MHSA PEI) based on the need to provide preventative services to our youngest children. The most effective way to provide these services as well as the strengths and gaps in care for young children in Alameda county will be addressed in this report. The recommendations address the local community mental health needs of at-risk children (a subset of the "At-Risk Children, Youth and Young Adult Populations) and also address "Disparities in Access to Mental Health Services." While the primary priority populations served are "Children/Youth in Stressed Families" these recommendations and

strategies also address "Trauma-Exposed Children," "Children at Risk for School Failure," and "Children and Youth at Risk of Juvenile Justice Involvement."

The statistics demonstrate that despite a child's resilience, problems often manifest themselves when children are young. Research shows that early interventions can help; however children and families are suffering because of missed opportunities for prevention and early intervention. Although services for young children are not always provided, the need is clear.

- For every 133 pre kindergarten students in California, one is expelled- this is three times the rate of expulsion in California K-12 schools.
- The brain goes through explosive growth in the first three years of a child life; however neglect can alter brain growth.[1]
- 39 percent of the substantiated Alameda County child abuse referrals to Child Welfare Services were children birth to five.

Research has identified a set of "risk factors," or economic, social and psychological stressors, that increase the odds that children will struggle with later social, emotional, and cognitive difficulties. Further research has found that it is not the presence of any one particular risk factor but rather the combination of multiple risks that best predicts the emotional and academic status of children over time. The risk factors, or stressors, that predispose some children to greater risk for developing a mental disorder include:[2,3,4] poverty, single parent status, low birth weight, exposure to environmental toxins, child abuse and neglect, exposure to traumatic events or violence, homelessness, disability, chronic illness, or other special needs within the immediate family, low proficiency in English[5] the presence of a mental disorder in a parent (maternal depression is a particularly potent risk factor for young children)[6], and prenatal damage from exposure to alcohol, illegal drugs, and tobacco. The purpose of the Prevention and Early Intervention dollars are well aligned with our goals which are to promote social emotional well being in Alameda County families by intervening early in the lives of our youngest citizens.

Although Alameda County has strong collaboration between community partners and a knowledgeable and skilled 0-5 provider network, there are still many children who are not receiving needed prevention and early intervention services. This is especially true for young children living in multi stressed families. Young children from birth to age five are in the early stages of their social-emotional development and ability to form relationships, thus it is an opportune time to provide services. Despite the fact that the statistics show that problems begin manifesting themselves at a young age and research has shown that early interventions can ameliorate the problem, young children are frequently overlooked. The committee has identified the following gaps in service provision:

1. ***A lack of prevention and early intervention services for children who are not eligible for Medi-Cal or other public funding.***
2. ***There are many populations underutilizing mental health services because the structure and implementation of services does not honor the unique cultural and linguistic needs of Alameda County families.***
3. ***There are many adults with mental health issues being served by the adult mental health system but not enough attention is paid to whether there are children in the home who also need support and intervention.***

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[1] Perry, BD and Pollard, D. *Altered brain development following global neglect in early childhood.* Society For Neuroscience: Proceedings from Annual Meeting, New Orleans, 1997

[2] Shore, R. Rethinking the brain; new insights into early development. New York: Families and Work Institute, 1997.

[3] National Institute for Health Care Management Foundation. Children's Mental Health: An Overview and Key Considerations for Health System Stakeholders. February: 2005.

[4] Raver, C. Cybele and Knitzer, Jane. Promoting the Emotional Well-Being of Children and Families, Policy Paper No. 3, "Ready to Enter: What Research Tells Policymakers About Strategies to Promote Social and Emotional School Readiness Among Three- and Four- Year-Old Children." National Center for Children in Poverty: July, 2002.

[5] Families with low proficiency in English generally have to cope with greater hardship and more limited access to fewer resources, and their children's odds of doing well are correspondingly, lower.

[6] In 2005-06 in Alameda County 51 percent of children of mothers involved in intensive family support through Every Child Counts who screened positive for depression had a child with at least one identified area of developmental concern compared to 44 percent children of mothers who did not screen positive (First 5 Annual Report 2005-2006).

The strategies identified by the Early Childhood Mental Health Planning Committee builds the capacity for providing mental health early intervention services at sites where people go for other routine activities, such as child care, health providers, and community organizations. These programs all engage children prior to the development of serious mental illness. These programs, all of which have been proven to be effective, seek to intervene with at-risk children and their families before problems become entrenched and impact a child's functioning in school and the community.

The recommendation is to focus services on children who are now unable to be served with existing funding streams. These are children living in homes with multiple stressors and in communities with high rates of poverty, large numbers of immigrant families, and low test scores. Underserved families and geographic locations should be targeted. These services intentionally expand the service locations beyond traditional mental health sites in order to provide more non-traditional community based support, serve the underserved populations that are the most in need, and reach children who have been exposed to violence.

1) ***Mental health consultation services at:***
    a. ***Child care.*** On-site mental health consultation helps promote early identification and intervention for social and emotional difficulties. Weekly observations of teachers and children in the classroom, consultation, education, and support for teachers, consultation for directors, and referral of children and families who need further services leads to improvement in the overall relationships between the children and the teachers, the teachers and the directors, and the teachers and the parents.
    b. ***Community-based settings/locations.*** Early childhood mental health consultants in community based settings help providers who are already serving families in need understand how to identify potential mental health concerns in young children as well as help providers develop referral pathways for children who need treatment.
    c. ***Primary care setting:*** Mental health consultants working with primary pediatric providers and clinic settings, increase the medical provider's ability to identify potential mental health concerns in young children as well as provide screening and assessment of children who may need additional support services to ensure social emotional well being.

2) Assessment and Targeted Caregiver/Child Early Interventions including those that focus on:
    a. Individual families. These programs provide more intensive support to families by working with a caregiver and a child to strengthen their relationships in order to improve the child's social-emotional health. These services are offered in the home, community and clinics.
    b. Group strategies: Group strategies such as; developmental playgroups, the Nurturing Parenting Program, and the Circle of Security assist young children and their families to receive intervention from professionals as well as from their peers. These services are offered in locations that are community based and easily accessible and can be offered in a variety of languages.

The strategies recommended will have individual and family outcomes including:

- Child care providers, pediatric care providers, community-based providers, and parents will show an increased knowledge of the social, emotional, and behavioral development of young children.
- The children served will have improved mental health status.
- Parent-child relationships will improve.
- Increased number of children with secure attachment that will support development of later resilience.

Recommendations for the Early Childhood Mental Health Planning Committee to Alameda County BHCS Mental Health Services Act Prevention and Early Intervention

Overview

The Early Childhood community has worked collaboratively for more than a decade to improve and expand services for young children zero to five in Alameda County. . The committee recognizes the importance or providing integrated services to children throughout the developmental continuum in to adulthood. Research demonstrates that the earlier systems can support resilience in young children and families, the better the long term outcomes. Providing prevention and early intervention to children and their families as early as possible can prevent the financial burden across systems such as mental health, special education, child welfare and juvenile justice in later years.

The Alameda County Early Childhood Mental Health Planning Committee consists of providers from a variety of county, public and community-based organizations and child care planning council staff (see Appendix A for a complete list). This group is recommending a set of services for funding through the Mental Health Services Act Prevention and Early Intervention Program (MHSA PEI).

Although Alameda County has strong collaboration between community partners and a knowledgeable and skilled 0-5 provider network, there is a need to provide prevention and early intervention to young children experiencing multiple stressors. Young children from birth to age five are in the early stages of their social-emotional development and ability to form relationships, thus it is an opportune time to provide services. Despite the fact that the statistics show that problems begin manifesting themselves at a young age and research has shown that early interventions can ameliorate the problem, young children are frequently overlooked. The problem is compounded by the difficulties in reaching isolated and underserved communities of parents whose children may be in need of support in order to prevent mental health disturbances later in life.

The committee has identified the following gaps in services for young children in our county:

- A lack of prevention and early intervention services for children who are not eligible for Medi-Cal or other public funding.

- Children and families underutilizing mental health services because the structure and content of services does not honor the unique cultural and linguistic needs of their family.

- There are many adults with mental health issues being served by the adult mental health system but not enough attention is paid to whether there are children in the home who also need support and intervention.

The Alameda County Early Childhood Mental Health Planning committee, through the knowledge of the experts sitting on the group, community input, and lessons learned from the community, recommends that Alameda County use a portion of the Mental Health Service Act Prevention and Early Intervention funding to support the following strategies that have been proven to be effective:

- Mental health consultation at child care, primary medical care settings, and community-based locations (e.g. homeless shelters serving families, perinatal drug treatment programs and domestic violence programs)

- Assessment and Brief Early Intervention Strategies for

    - individual families
    - group strategies (e.g. maternal depression support groups, parent-child developmental play groups, circle of security)

Alameda County has a strong existing collaboration of early childhood mental health providers, which has been strengthened over the last 8 years through the work of First 5 Alameda County, Safe Passages, the Oakland Fund for Children & Youth, the expansion of EPSDT funding, and the Harris Training Program. The provider network has the expertise to provide services and outreach to underserved populations. The committee would like to see the recommended services funded in order to expand consultation and early intervention services available in our community. This expansion will create a continuum of services ranging from prevention to early intervention and treatment. The expanded continuum of services will begin to meet the goal of transforming the mental health system to identify and support the healthy social and emotional wellbeing of our county's youngest citizens.

Introduction

This brief will provide information on: 1) the need to provide preventative services to our youngest children and 2) effective strategies to address the need including the gaps in service, and 3) recommendations for how to most effectively use MHSA PEI funding.

Early Childhood: A Critical Time for Mental Health Prevention and Early Intervention

Young children from birth to age five, in the early stages of their social-emotional development and ability to form relationships, are in need of services, and yet are frequently overlooked.

An estimated 1 in 10 children and adolescents in the United States suffers from mental illness severe enough to cause some level of impairment; however research suggests that many mental health problems and disorders in children might be prevented or ameliorated with prevention, early detection and intervention. Overall, prevention and early intervention efforts targeted to children, youth and their families have been shown to be beneficial and cost-effective and reduce the need for more

costly interventions and outcomes such as welfare dependency, juvenile detention, grade retention, and special education services. Early intervention efforts can improve school readiness, health status, academic achievement, and improve the likelihood that children will develop appropriately in social-emotional and cognitive arenas.[1]

Young children though frequently overlooked, have a clear need for services. In Alameda County there are approximately 121,000 children between the ages of 0-5. Young children are not being served at the same rate as other age groups. Between April 1 and June 30, 2007 only 2.1 percent of total Medi-Cal beneficiaries between the ages of 0-5 were served, compared to 8.0 percent of 6-17 year olds, 4.2 percent of 18-24 year olds and 11 percent of 25-58 year olds. Although services for young children are not always provided, they are needed:

- For every 133 pre kindergarten students in California, one is expelled- this is three times the rate of expulsion in California K-12 schools.

- The brain goes through explosive growth in the first three years of a child life; however neglect can significantly alter brain growth impacting a child's ability to function at an optimal level in preschool and in the community.

- 39% percent of the substantiated Alameda County child abuse referrals to Child Welfare Services were children birth to five.

The statistics show that not all children are resilient. Problems often manifest in the youngest years when children are most vulnerable. Research demonstrates that early intervention can make a significant difference in getting children off to a better start. Unfortunately young children and families are suffering unnecessarily because of missed opportunities for prevention and early intervention.

Providing Services to Young Children

The early experiences and relationships of young children set the stage for how they manage their feelings and impulses and their ability to relate to others. Early childhood is the foundation for their emotional and behavioral health.[2] Early mental health problems should be addressed in the context of the child's primary relationships.[3] For young children this means promoting an increase in the parent's responsiveness to the child's needs. This strengthens the child's trust in the parent's capacity to provide care.[4] For preschool-aged children, research supports the use of

[1] National Institute for Health Care Management Foundation. Children's Mental Health: An Overview and Key Considerations for Health System Stakeholders. February: 2005.
[2] Raver, C. Cybele and Knitzer, Jane. Promoting the Emotional Well-Being of Children and Families, Policy Paper No. 3, "Ready to Enter: What Research Tells Policymakers About Strategies to Promote Social and Emotional School Readiness Among Three- and Four- Year-Old Children." National Center for Children in Poverty: July, 2002.
[3] Lieberman, Alicia F., Patricia Van Horn, and Chandra Ghosh Ippen, "Toward Evidence-Based Treatment: Child-Parent Psychotherapy with Preschoolers Exposed to Marital Violence." Psychiatry, December: 2005.
[4] Lieberman, Alicia F., Patricia Van Horn, and Chandra Ghosh Ippen, "Toward Evidence-Based Treatment: Child-Parent Psychotherapy with Preschoolers Exposed to Marital Violence." Psychiatry, December: 2005.

interventions that target both parents and caregivers/teachers.[5] In all cases, treatment for young children is most effective when administered in the child's natural environment such as the home or child care setting. In addition, when children are identified and services are provided, the impact is experienced by more than on a single child. Services also affect the needs of the caregivers and siblings.

Children Most at Risk

Research has identified a set of "risk factors," or economic, social and psychological stressors, that increase the odds that children will struggle with later social, emotional and cognitive difficulties. Further, research has found that it is not the presence of any one particular risk factor but rather the combination of multiple risks that best predicts the emotional and academic outcomes of children over time. The risk factors, or stressors, that predispose some children to greater risk for developing a mental disorder include:[6,7,8]

- Poverty,
- Single parent status,
- Low birth weight,
- Exposure to environmental toxins,
- Child abuse and neglect,
- Exposure to traumatic events or violence,
- Homelessness,
- Disability, chronic illness, or other special needs within the immediate family,
- Low proficiency in English[9]
- The presence of a mental disorder in a parent (maternal depression is a particularly potent risk factor for young children)[10], and
- Prenatal damage from exposure to alcohol, illegal drugs, and tobacco.

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[5] Raver, C. Cybele and Knitzer, Jane. Promoting the Emotional Well-Being of Children and Families, Policy Paper No. 3, "Ready to Enter: What Research Tells Policymakers About Strategies to Promote Social and Emotional School Readiness Among Three- and Four- Year-Old Children." National Center for Children in Poverty: July, 2002.

[6] Shore, R. Rethinking the brain; new insights into early development. New York: Families and Work Institute, 1997.

[7] National Institute for Health Care Management Foundation. Children's Mental Health: An Overview and Key Considerations for Health System Stakeholders. February: 2005.

[8] Raver, C. Cybele and Knitzer, Jane. Promoting the Emotional Well-Being of Children and Families, Policy Paper No. 3, "Ready to Enter: What Research Tells Policymakers About Strategies to Promote Social and Emotional School Readiness Among Three- and Four- Year-Old Children." National Center for Children in Poverty: July, 2002.

[9] Families with low proficiency in English generally have to cope with greater hardship and more limited access to fewer resources, and their children's odds of doing well are correspondingly, lower.

[10] In 2005-06 in Alameda County 51 percent of children of mothers involved in intensive family support through Every Child Counts who screened positive for depression had a child with at least one identified area of developmental concern compared to 44 percent children of mothers who did not screen positive (First 5 Annual Report 2005-2006).

Alameda County Mental Health Services for Young Children: Strengths and Gaps

Despite the increase in mental health consultation and EPSDT treatment services for young children in our county in the last 4 years, there are still children that are not being identified and served. These include: 1) children experiencing multiple stressors who are not eligible for Medi-Cal or other public funding, 2) children living in families that are underserved due to cultural and linguistic factors, 3) children living in the home of parents who have mental illness.

Specific strengths and gaps in the existing system have been identified through the expertise of the Alameda County Early Childhood Mental Health Planning Committee as well as the Alameda County Children's SART (Screening, Assessment, Referral and Treatment) planning process.[11]

Strengths in the System

Alameda County has many strengths including:

- ***Strong collaboration between community partners.*** Alameda County has a knowledgeable and skilled provider network serving young children 0-5 who have been working together collaboratively for nearly a decade. The collaboration has been strengthened over the last five years with the work of First 5 Alameda County, Safe Passages, Oakland Fund for Children & Youth, the expansion of EPSDT and the Harris Training Program. A commitment exists to establish and implement a family-centered, coordinated, accessible system of community support, prevention, and treatment that meets the developmental and behavioral needs of all Alameda County children 0-5. The collaboration has improved service delivery because agencies are learning to link and communicate with each other about referrals that may be better served by another agency's expertise.

- ***Experience and a diversity of expertise.*** A variety of community-based organizations with diverse specialties and expertise offer services in Alameda County allowing for service to be provided to a range of ethnically and otherwise diverse populations such as monolingual families and parents and caregivers with disabilities.

- ***Limited existing services.*** The last 5 years have shown an expansion of services for 0-5 year olds in our county. First 5 Alameda County supports some intensive home visiting programs and community grants that often

[11] In January 2007, First 5 Alameda County (Every Child Counts) spearheaded a county-wide planning process, in partnership with the County Health Care Services Agency, the Regional Center of the East Bay, and various Alameda County cities, school districts and county agencies. The goal of the planning effort was to enhance and strengthen screening, triage and referral, assessment and treatment services for children 0-5 at risk of developmental and/or social-emotional delays. A series of meetings including representatives from government agencies, service providers, and parents were held during the planning process. A list of people who contributed to the SART planning process is available upon request.

involve developmental screening of young children as well as supporting play activities for children. Mental health consultation has been expanded through the Safe Passages collaboration focusing on City of Oakland funding streams. The EPSDT providers serving children 0-5 meet monthly to discuss coordination issues.

- ***Training.*** The Harris Training Program trains community providers in early childhood mental health and has trained over 120 providers in the last 8 years. This program is collaboration between Children's Hospital, First 5 Alameda County and Behavioral Health Care Services.

Gaps in the System

Despite these strengths, there is a need to provide prevention and early intervention to young children experiencing multiple stressors. The following gaps in service provision have been identified:

- ***Early Identification and Screening of children who need services must be improved.*** It is important to ensure that children who may be at risk for mental health issues be identified as early as possible. Yet, we do not have a systematic way to screen and assess children who may be at high risk due to environmental, biological or parental risk factors. Standardized protocols for enhancing developmental screening and assessment in order to ensure that young children are identified as early as possible is crucial to ensure they receive needed services in order to promote their social and emotional well-being.[12]

- ***A lack of preventative or early interventions services for children who are not eligible for Medi-Cal or other public funding.*** Although Alameda County has expanded services to young children significantly over the last five years through a county-wide expansion of programs funded through Early Periodic Screening, Diagnosis, and Treatment (EPSDT); EPSDT funding does not cover; 1). children who need some intervention but are not on full scope medi-cal .2) preventative services such as mental health consultation to child care and other community environments or 3) early interventions for children , where environmental risk is high but children are not presently showing symptoms

- ***Access to care for underserved populations must be improved.*** Services that are offered are not always accessible. This may be due to a variety of factors such as: service delivery models which do not fit with cultural practices, lack of trained providers in languages other than English, transportation issues and family priorities. In order to improve access to underserved populations, services must be offered in languages other than English and provided in locations that are accessible for parents and other caregivers such as at their home, child care, doctor's offices, community centers, and/or religious

[12] There are several national initiatives to standardize screening in order to improve early identification of young children who need services, for example the American Academy of Pediatrics has recently published new recommendations on the use of standardized screening in primary care.

centers. A wide range of service locations expands the number of children reached. For example, immigrant communities may be less likely to use child care, but *are* likely to visit the pediatrician for a well-child visit. Home-based services are most feasible for families with parental or child disability or chronic illness and for families without access to good transportation.

- *A link must be made between parenting adults who are receiving services and their children who may be in need.* Another gap is making the connections between adults served in the mental health system and their children. While research has shown that the children of adults experiencing stressors such as poverty, mental illness, abuse, or disability are more likely to have social and emotional delays, services often do not look at the whole family. When adults are served, the system must be altered so that they are viewed as a gateway to the children. Additional links must be made so that when parenting adults receive services, connections are made to their children, allowing the whole family to receive adequate services. Conversely, a well designed system for of prevention and early intervention for children during their youngest years provides a gateway to identifying parents who may be in need of more intensive mental health services.

Filling the Gaps

Although there are many gaps in the system, the Alameda County Early Childhood Mental Health Planning Committee, through both the knowledge of the experts sitting on the group as well as community input through the Children's SART process and lessons learned from consumers, has identified the most pressing needs for the early childhood community.

The ECMH Planning Committee recommends that Alameda County BHCS utilize funds from the Mental Health Service Act Prevention and Early Intervention funding to support:

- Mental health consultation at child care, primary care settings, and community-based locations, and

- Assessment and Targeted Caregiver/Child Early Interventions including both parent-child and group strategies.

These strategies all of which have been proven to be effective, seek to intervene with at-risk children and their families before problems become entrenched and impact a child's functioning in school and the community. These services intentionally expand the service locations beyond traditional mental health sites in order to provide more non-traditional community based support and serve the underserved populations that are most in need. A community needs assessment has been completed through Alameda County Children's SART (Screening, Assessment, Referral and Treatment)

planning process, Measure Y[13], and the Mental Health Services Act Community Supports and Services process to establish where the underserved populations are in Alameda County. The recommendation is to use those findings to guide implementation of the strategies.

As the recommendations are implemented it will be critical to link with the implementation of Alameda County Children's SART system and to utilize the existing expertise in the County. Many agencies already exist in the county who have been trained and are ready to offer services if funding is made available to expand services. The Alameda County Early Childhood Mental Health Planning Committee would like to develop a centralized early childhood system with a designated lead agency. This should build off of the work that Alameda County First 5 has been doing and become part of the children's system of care.

Recommended Strategies for MHSA PEI Funding

Strategy 1
Expand Mental Health Consultation Services

The Workgroup recommends expanding mental health consultation and screening at child care, primary medical care settings, and community-based locations (e.g. homeless shelters serving families, perinatal drug treatment programs, domestic violence programs) as a form of preventative mental health. Young children may not yet have the verbal skills to tell adults what is happening in their life and; therefore, may communicate their feelings through their behavior. Early childhood mental health consultants[14] are objective observers who are trained and able to provide a preventative approach to improving mental health by focusing on building relationships and positive environments. Additionally, mental health consultants can raise the awareness of non mental health providers in the identification of emerging mental health concerns.

Child Care (Family and Centers)

Target Population

Mental health consultation services should be targeted at centers and home-based (family) child care sites throughout Alameda County that are located in zip codes with high rates of poverty and violence, large numbers of immigrant families, and low test scores in order to reach families with multiple stressors. Underserved families and geographic locations should be targeted.

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[13] On November 2, 2004, Oakland passed Measure Y, the Violence Prevention and Public Safety Act of 2004 (VPPSA). It is a parcel tax along with a parking surcharge on parking in commercial lots that includes funding for violence prevention programs.

[14] The consultants are social workers or therapists with a master's degree, but may come from a variety of professional backgrounds including licensed clinical social worker; marriage, family, and child therapist; clinical psychologist; psychiatrist; or developmental pediatrician.

Proposed Intervention

On-site mental health consultation helps promote early identification and intervention for social and emotional difficulties, thereby reducing more serious mental health problems.[15] Children attending preschool classrooms that are marked by close teacher-student relationships, low levels of problem behaviors, and opportunities for positive social interaction, are more socially competent and fare better academically during the first two years of elementary schooling, than do children from more disruptive classrooms.[16]

Mental Health consultation services in child care focus on the classroom as a whole and not on individual children. The goal is to improve the overall relationships between the children and the teachers, the teachers and the directors, and the teachers and the parents. The improved relationships decrease problematic behavior in the classroom. Individual children who continue to have problems receive more individual support either by the consultant or through case management and referral. The intervention has a broader impact because future children enrolled at the site also benefit from the services. Mental Health Consultation services in child care generally consist of weekly observations of teachers and children in the classroom, consultation, education, and support for teachers, consultation for directors, and referral of children and families to services.

Mental health consultation services are currently being offered through the Safe Passages Early Childhood Initiative[17] and Alameda County First 5 Every Child Counts (See Attachment B), Alameda County Behavioral Health Care Services, as well as individual contracts between Head Start and other child care providers and Early Childhood Mental Health agencies. There are a number of agencies, already trained in childcare consultation models outlined in the Mental Health Services Act Prevention and Early Intervention resource materials provided by the California Department of Mental Health (see www.ucsfchildcarehealth.org/pdfs/Curricula/CCHC/14_CCHC_Behavioral_0406.pdf) , who could expand their capacity to serve more locations. See www.acgov.org/childcare/documents/early_childhood_directory.pdf for a directory of agencies providing services in Alameda County.

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[15] California Childcare Health Program, "Behavioral Health" First 5 California, 2006, www.ucsfchildcare.org.

[16] Raver, C. Cybele and Knitzer, Jane. Promoting the Emotional Well-Being of Children and Families, Policy Paper No. 3, "Ready to Enter: What Research Tells Policymakers About Strategies to Promote Social and Emotional School Readiness Among Three- and Four- Year-Old Children." National Center for Children in Poverty: July, 2002.

[17] The Safe Passages Early Childhood Initiative implements a continuum of services including the Second Step Violence Prevention Curriculum, Mental Health Consultation, Case Management, and other more intense interventions such as Parent/Infant Psychotherapy to children from birth to five, living in neighborhoods with high concentrations of poverty, high levels of community and domestic violence and a lack of access to health and mental health services.

Intended Outcomes

- The social and emotional needs of young children receiving mental health consultation will be met by the early care and education classroom environment.
- The teachers will increase their awareness of how to promote social and emotional health in their classrooms.
- Early care and education teachers will increase their ability to improve the mental health of young children in their care.

Methods of outcome measurement will be selected to fit final program design.

Community Based Settings/Locations

Target Population

Mental health consultation services should be targeted at community-based settings that serve families of children 0-5 where traditionally the focus has not been on the children such as: domestic violence shelters, transitional housing, faith-based institutions, disability organizations and adult mental health programs that have not focused on the needs of the child. All proposed services would be located in zip codes with high rates of poverty and violence, large numbers of immigrant families, and low Academic Performance Index scores in order to reach families with multiple stressors. Underserved families and geographic locations would be targeted.

Proposed Intervention

Early childhood mental health consultants in community based settings help providers who are already serving families in understanding how to identify potential mental health concerns in young children as well as help providers develop referral pathways for children in need of early intervention and treatment. The intent of working in non-traditional settings is to reach underserved children who may not be part of other systems. Consultants would work with staff in the community based setting weekly to provide support to staff as well as directly interact with children and families.

Intended Outcomes

- Increased awareness/training of non mental health staff/providers on how to support the social-emotional health of young children.
- The mental health of young children receiving mental health consultation services will show significant improvement as rated by parents, community service providers, mental health consultants and early intervention providers.
- Increased early identification of children who may have social-emotional and/or developmental delays as demonstrated by age at the time of referral and an increase in the number of referrals.

Methods of outcome measurement will be selected to fit final program design.

Primary Medical Care Settings

Target Population

Mental health consultation services will be targeted at primary pediatric care clinics serving young children 0-5 with multiple stressors such as: Child Health and Disability Prevention (CHDP) providers, County and Community Clinics which serve low-income families, or other clinics serving families with multiple stressors. Primary Care Medical settings are a prime way to reach underserved families who may not have relationships with any other existing service providers. Geographic locations with the highest needs will be targeted.

Proposed Intervention

Providing mental health consultation at primary medical care sites, a recommended MHSA PEI strategy that increases the providers' (pediatrician or other primary care provider) understanding of how to identify potential mental health concerns in young children as well as provide screening and assessment of children who may need additional support services. The mental health consultant works with the pediatrician so that the focus becomes the child's physical health, mental health, behavior and development. The pediatrician and consultant function as a team to discuss the child's needs with the parent. The consultants will work with the provider by providing screening and assessments of the child. The mental health consultant provides case management for children who are eligible for other services, or can provide additional, more intensive short term services for children who are not eligible for other services. One local model that can be built upon is the Family Outreach Support Clinic at Children's Hospital. This clinic which serves children who are associated with the child welfare system (either in the system now, were previously in, or are in danger of being in), provides services two mornings a week where a social worker and a pediatrician function as a team to provide comprehensive and preventative services to children and their families in the clinic setting.

Intended Outcomes

- Increased awareness of pediatric and primary care providers on how to support the social-emotional health of young children.
- Increased early identification of children who may have social-emotional and/or developmental delays as demonstrated by age at time of referral and an increase in the number of referrals.
- The mental health of young children receiving mental health consultation services will show significant improvement as rated by primary care providers and parents

Methods of outcome measurement will be selected to fit final program design.

Strategy 2
Assessment and Targeted Caregiver/ Child Early Intervention

The Workgroup recommends funding an additional targeted strategy for early intervention: Assessment and Brief Early Interventions offered to:
1) individual parent(s)-child (ren) and 2) group early intervention strategies in community settings.
This strategy would combine assessment of young children with brief early interventions and would be be implemented at a variety of community based locations in order to reach traditionally underserved populations. Home based services would be offered as well a group services at family resource centers, clinics, religious institutions and other sites that serve families who are traditionally "hard to reach."

Parent-Child Intervention

Target Population

Parent-Child Interventions are for young children 0-5 who are at risk for social-emotional or developmental problems as a result of multiple stressors such as community and family violence, parental depression, substance use, disability, and other stressors that highly correlate with poor outcomes in young children. Families can be referred from pediatric providers, child care providers/teachers, nurses, social workers, child protective services, community-based organizations, emergency room staff, or others. Children would be offered assessment which would identify their ongoing needs and brief early intervention would be offered to parent-child dyads that cannot receive services under an existing funding stream. Children living in the highest risk neighborhoods would be targeted for these interventions.

Proposed Intervention

Parent-Child Interventions are based on models similar to those offered in the Infant Parent Program (IPP), which is one of the promising programs outlined in the Mental Health Services Act Prevention and Early Intervention resource materials (see http://mentalhealth.samhsa.gov/_scripts/printpage.aspx?FromPage=http://mentalhealth.samhsa.gov/publications/allpubs/KEN02-0133/infant.asp).

These interventions support a child's social-emotional health through strengthening parent (or caregiver) - child relationships. Early mental health specialists observe and work with caregiver/child dyads, providing facilitation of interaction as well as developmental guidance. They help caregivers articulate the aspects of parenting that bring up negative emotional feelings and that block the caregiver from responding appropriately to their child. Particularly for families with multiple stressors, they provide a brief and early family intervention targeting issues that impact the social- emotional development of children. As families need emotional

support, the early interventionist can listen to and elicit information from caregivers and children to support healthy emotional development by providing developmental guidance about age-appropriate behaviors, issues and concerns.

Intended Outcomes

- The mental health of young children receiving mental health consultation services will show significant improvement as rated by parents, mental health providers and early intervention providers.
- Parents will increase their ability to improve the mental health of their young children.
- Parent child relationships will improve as demonstrated by ratings by parents and mental health providers.
  Methods of outcome measurement will be selected to fit final program design.

Group Interventions

Target Population

The group interventions would target children who have been identified as at risk for social-emotional or developmental delays, in particular, for children for whom services are not funded through the Regional Center or School District. These children may be identified by a developmental screen or assessment and can be referred through friends, flyers, pediatric provider offices, community clinics, child care providers/teachers the regional center (children that do not meet eligibility), or community based organizations. Group interventions can be targeted at: : 1) Pregnant and parenting teens and, 2) parents who have been referred by CPS for abuse or neglect, and 3) parents with problems with substance use, a mental illness, or other disability. These are populations that are traditionally underserved. Services can be implemented in the highest risk neighborhoods in Alameda County.

Proposed Intervention

Group interventions are a good family support strategy that serves people who otherwise may not be served. They can be offered in locations and in formats that may be more accessible to groups whose cultures stigmatize mental health. The following three programs are illustrative of the type of group interventions that need to be provided.

- *Developmental Playgroups* Young children identified with communication and social-emotional concerns will be better prepared to enter pre-school/kindergarten if they participate in developmental playgroups. A limited number of developmental playgroups are currently offered in Alameda County and preliminary results are promising (please see Attachment C). These playgroups have been particularly successful in the Latino community. Developmental playgroups provide therapeutic and developmentally enriched environments for parents and young children to engage in parent/child

interactions that assist with social and emotional development. Playgroups are generally offered once a week for a four to six month period. These playgroups are often staffed by mental health and child development specialists at community based locations convenient for parents. It is important to offer groups in Cantonese, Vietnamese, Spanish, English, and Farsi. Agencies receive training on administering the Ages and Stages Questionnaire, conducting successful outreach, and addressing cultural differences in child rearing and parent-child interaction.

- *Nurturing Parenting Program* Programs like the Nurturing Parenting Program (www.nurturingparenting.com), designated as a MHSA Promising Program, can be implemented in a variety of environments including home, church, or community-based organizations. The program curriculum consists of separate curriculum for parents and for the children. The content of the parent portion of the program focuses on increasing self-esteem and self-concept while teaching nurturing parenting skills appropriate for the age group of the child. Sessions are generally on a weekly basis and last from one to one and half hours. Groups are co-lead by multidisciplinary team of social worker/case managers, child development specialists and mental health specialists. Participants who need more case management services can also be linked to home visiting programs.

- *Circle of Security* is an evidence-based early intervention program for parents and children to help parents better understand the needs of their children (see www.circleofsecurity.org). There has been recent training in Circle of Security in Alameda County. The group intervention provides parent education and psychotherapy that is based on attachment theory. The intervention is based on the assumptions that the quality of a parent-child attachment: 1) can be changed, 2) plays a significant role in the life of a child, and 3) lasting change comes from the parents' ability to develop specific relationship capacities. The weekly intervention lasts 20 weeks and takes place in groups of five to six caregivers with an individualized plan for each dyad.

Intended Outcomes

- Parents will increase their understanding of typical and atypical early child development, which will contribute to increased understanding of their own child's social emotional resilience.
- Parents will report improved ability to meet their child's social emotional development needs and increase their child's resilience as a result of support from other parents, mental health providers and early intervention providers. **Methods of outcome measurement will be selected to fit final program design.**

Summary

The above proposed strategies will expand already existing Alameda County prevention and early intervention efforts. Expansion of these services will assist in

the development of a system of care for young children and their parents/caregivers. Intervening at the earliest possible time when risk for mental health problems is identified will give us the greatest chance of preventing later more expensive costs to society. Our youngest citizens in Alameda County do not have their own voice to speak up for needed support. It is a shared community responsibility to ensure that young children have the best possible chance for a successful life.

Linking Recommended Strategies with MHSA PEI

	Mental Health Consultation	Targeted Caregiver/Child Early Interventions
Cultural Competence	The cultural and linguistic needs of the community will in part be addressed by recruitment of staff from the community. In addition, the variety of locations for consultation reaches a larger community with the understanding that different cultures utilize different services.	The cultural and linguistic needs of the community will in part be addressed by recruitment of staff from the community. Additionally, cultural values, practices and beliefs will be incorporated as much as possible in the implementation of strategies, as will the linguistic needs of the community.
Individual/Family-driven with Specific Attention to Individuals from Underserved Communities	Paid family partners (parents and caregivers who have used services) will be offered to parents receiving services. Additionally, family members will be actively involved in the planning and implementation of the proposed strategies as much as possible. Focus groups and surveys are conducted with families for planning and evaluation.	Paid family partners (parents and caregivers who have used services) will be offered to parents receiving services. Additionally, family members will be actively involved in the planning and implementation of the proposed strategies as much as possible. Focus groups and surveys are conducted with families for planning and evaluation.
Wellness Focus	These programs are strength-based and relationship-based models. Early childhood mental health is rooted in relationship-based models that emphasize a family's strengths, ability to problem solve, and resilience.	These programs are strength-based and relationship-based models. Early childhood mental health is rooted in relationship-based models that emphasize a family's strengths, ability to problem solve, and resilience.
Integrated Service Experience for Individuals and their Families	Mental health consultation services are designed to provide services in a location where families are already accessing services: child care, primary care, and community-based organizations. When families need to navigate other systems they will receive additional case management.	The parent-child early intervention is designed to serve families in places of convenience and where they can obtain other supports. The locations are flexible to ensure that the families most in need receive services. Families will be linked to additional services when needed through a case management model.
Collaboration and System Enhancements	Through the Early Childhood Mental Health Services Development Workgroup, Every Child Counts, and Safe Passages there is a large collaboration between the County, Community	Through the Early Childhood Mental Health Services Development Workgroup, Every Child Counts, and Safe Passages there is a large collaboration between the County, Community

	Providers, Children's Hospital Oakland, child care programs and the school districts. This collaboration will work together to facilitate planning and to ensure that services are provided effectively.	Providers, Children's Hospital Oakland, child care programs and the school districts. This collaboration will work together to facilitate planning and to ensure that services are provided effectively.
Key Community Mental Health need	• Disparities in Access to Mental Health Services • At-Risk Children, Youth and Young Adult Populations	• Disparities in Access to Mental Health Services • At-Risk Children, Youth and Young Adult Populations • Psycho-Social Impact of Trauma
Priority Population	• Children and Youth in Stressed Families • Children and Youth at Risk for School Failure	• Trauma-Exposed Individuals • Children and Youth in Stressed Families • Children and Youth at Risk for School Failure

Appendix 1

Alameda County Early Childhood Mental Health Planning Committee Members

David	Channer	A Better Way
Josephina	Alvarado	Safe Passages/ Youth Ventures
Sujata	Bansal	First 5
Kim	Beckham	Family Paths
Jane	Bernzweig	First 5
Fiona	Branagh	Alameda County Behavioral Health Care Services
Deborrah	Bremond	First 5
Irene	Casanova	Tiburcio Vasquez Health Center
Lynn	Chung	Alameda County Public Health Department/Maternal and Child Health
Marge	Deichman	Alameda County Public Health Department Family Health
Idabelle	Fosse	Safe Passages/ Youth Ventures
Angie	Garling	Child Care Planning Council
Obie	Gilkerson	Private practice
Sue	Greenwald	First 5/ Children's Hospital
Margie	Gutierrez-Padilla	Alameda County Behavioral Health Care Services
Megan	Kirshbaum	Through the Looking Glass
Diana	Kronstadt	Children's Hospital
Julie	Kurtz	Kidango, Inc.
Barbara	McCullough	Brighter Beginnings
Rachel	Metz	Consultant
Carolyn	Novosel, LCSW	ACBHCS Alameda County Behavioral Health Care Services
Grace	Orenstein	The Link to Children
Alicia	Perez	Safe Passages/Youth Ventures
Iris	Preece	City of Fremont YFS
Marcella	Reeves	Family Paths
Quinta	Seward	Safe Passages/Youth Ventures
Jennifer	Shallot	Brighter Beginnings
Barbara	Silver	Family Paths

Carol	Singer	Jewish Family and Children's Services
Nancy	Sweet	Children's Hospital
Nadiyah	Taylor	Child Care Planning Council
Esther	Wong	Asian Community Mental Health

Additional Appendices

Appendix 2 — **Participants in SART Planning Process**
This listing shows all the agencies and individuals that participated in the countywide Screening, Assessment, Referral and Treatment planning process. This PEI report focuses on recommendations that were made by that group for increased screening, assessment, treatment and community supports

Appendix 3 — **Early Childhood Mental Health: A Sound Investment for Alameda County**
This PowerPoint was developed to use with policy makers throughout the County to show the cost savings benefits of investing in prevention and early intervention at the youngest possible age.

Appendix 4 — **Highlight: Four Year's of Mental Health Consultation to Childcare**
This data is from the First 5 Alameda County Annual Report 2006-07.

Appendix 5 — **Partnership Grants- Parent Child Developmental Playgroups**
This data is from the Alameda County First 5 Annual report and outlines how developmental playgroups can provide early intervention for children who may be at risk for social emotional delays.

APPENDIX 2
SART PLANNING PARTICIPANTS

Alameda County Children's SART Planning Process Leadership Team			
Name	Organization	Name	Organization
Mark Friedman	Every Child Counts, First 5 Alameda County	Ingrid Lamirault,	Alameda Alliance for Health
Dave Kears	Alameda County Health Care Services Agency	Dr. Art Chen	Alameda Alliance for Health
Chet Hewitt	Alameda County Social Services Agency	Dr. Pam Simms Mackey	Children's Hospital and Research Center at Oakland
Dr. Anthony Iton	Alameda County Public Health Department	Dr. Renee Wachtel	Children's Hospital Oakland Division of Developmental and Behavioral Pediatrics
Dr. Marye Thomas	Alameda County Behavioral Health Care Services	Alice Lai Bitker	Alameda County Supervisor, District 3
Jim Burton	Regional Center of the East Bay	Keith Carson	Alameda County Supervisor, District 5
Josephina Alvarado Mena,	Youth Ventures	Andrea Youngdahl	City of Oakland Health and Human Services

Alameda County Children's SART Planning Process Steering Committee			
Name	Organization	Name	Organization
Alex Briscoe	Alameda County Health Care Services Agency	Suzanne Shenfil	City of Fremont Health and Human Services
Kate Warren	Family Resource Network	Andrea Youngdahl	City of Oakland Health and Human Services
Lynn Chung	Alameda County Public Health Department/ Maternal and Child Health	Dr. Linda Rudolph	City of Berkeley Public Health Department
Wanda Davis	Regional Center of the East Bay	Suzanne Nelson	North Region SELPA
Marge Deichman	Alameda County Public Health Department/ Family Health Services	Angie Garling	Alameda County Childcare Planning Council
Margie Padilla	Alameda County Behavioral Health Care Services	Erica Shore	Alameda County Department of Social Services, Children and Family Services

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Alameda County Children's SART Planning Process Stakeholders Group			
Name	Organization	Name	Organization
Alferma Crawford	Oakland Head Start	Hector Mendez	La Familia
Alisa Burton	City of Oakland Head Start	Iris Preece	City of Fremont Health and Human Services
Anna Wang	Friends of children with Special Needs	Jennifer Shallat	The Perinatal Council/Brighter Beginnings
Arlene Purcell	East Bay Community Recovery Project/ Project Pride	Jill Ellis	Center for Early Intervention on Deafness
Barbara Garcia	Alameda County Developmental Disabilities Council	Jill Rian	Alameda County Social Services/Children and Family Services
Barbara Bunn-McCullough	Perinatal Council/Brighter Beginnngs	Joan Suflita	Unity Council
Barbara Ramsey	Alameda Health Consortium	Joel Garcia	Tiburcio Vasquez Health Center
Barbara Silver	Family Paths	Joy Sarraga	City of Oakland Safe Passages

Carol Brown	City of Berkeley Public Health Department	Julie Kurtz	KIDANGO
Carol Haberberger	Berkeley Albany YMCA Head Start	Julie Weber	Newark Unified school district
Carol Singer	Jewish Family and Children's Services	Karen Saucedo	New Haven Unified School District
Carolyn Novosel	Alameda County Behavioral Health Care Services	Katherine Chun	Asian Community Mental Health
Charlene Okamoto	Fremont Unified School District	Kathryn Orfirer	Children's Hospital Oakland Center for the Vulnerable Child
Dana E. Ashby	Oakland Unified School District	Kathy Flores	San Lorenzo School District Autism Services
Diana Kronstadt	Children's Hospital Center for the Vulnerable Child	Kathy Moniz	New Haven Unified School District
Elizabeth Acosta Crocker	Children and Family Services Unity Council Head Start	Kimberly Beckham	Family Paths
Elizabeth Ford	Every Child Counts, First 5 Alameda County	Kim Marshall	Childcare Links
Felton Owens	Berkeley Unified School District	Kris Rydecki	Center for Early Intervention on Deafness
Grace Manning-Orenstein	The Link to Children	Laura Sprinson	Seneca Center
Heather Lang	BANANAS	Laurie Soman	Lucille Packard Children's Hospital Medical Home Project
Hector Mendez	La Familia	Lisa Kleinbub	Regional Center of the East Bay
Iris Preece	City of Fremont Health and Human Services	Rebecca Gebhart	Every Child Counts, First 5 Alameda County
Lou Fox	Family Support Services of the Bay Area	Reva Srinivasan	City of Fremont Infant and Toddler Program
Marsha Luster	Children's Hospital Oakland Social Services Department	Rocio de Mateo Smith	Area Board 5 on Developmental Disabilities
Megan Kirshbaum	Through the Looking Glass	Sharyn McDavid	4 C's of Alameda County
Molly Keith	Child, Family, and Community Services, Inc.	Sonia Waters	Family Resource Network (Parent)
Mary Anne Nielsen	Diagnostic Center, Northern California	Steve Eckert	East Bay Agency for Children
Nadiyah Taylor	Child Care Planning Council	Sujata Bansal	Every Child Counts, First 5 Alameda County
Nancy Sweet	Children's Hospital Oakland Early Intervention Services	Susan Ono	Asian Community Mental Health
Naomi Bagby	Alameda County Medical Center Highland Hospital	Usana Pulliam	City of Oakland Head Start
Naomi Toocano-Guiterrez	Every Child Counts, First 5 Alameda County	Valesca Santos	Family Resource Network
Pamm Shaw	Berkeley/Albany Head Start	Yaneth Maldonado	Family Resource Network

Alameda County Children's SART
Planning Process Administrative and Facilitation Team

Name	Organization	Name	Organization
Janis Burger	Every Child Counts, First 5 Alameda County	Kayce Garcia Rane	Resource Development Associates
Sue Greenwald	Every Child Counts, First 5 Alameda County/ Children's Hospital Oakland Early Intervention Services	Robert Ogilvie	Resource Development Associates
Deborrah Bremond	Every Child Counts, First 5 Alameda County	Dr. Ira Chasnoff	NTI Upstream, Children's Research Triangle

Alameda County Children's SART
Screening Workgroup

Name	Organization	Name	Organization
Alisa Burton	City of Oakland Head Start	Lynne Rodezno	Oakland Unified School District
Alison Pulice	Alameda County Public Health Department/ CHDP Program	Marge Deichman	Alameda County Public Health Department/ Family Health Services
Angie Garling	Local Planning Council	Nancy Lee	Every Child Counts, First 5 Alameda County
Carol Harberger	BAYMCA ECS	Robert Ogilvie	Resource Development Associates
Dr. Brian Blaish	Oakland Pediatrics & Behavioral Medicine	Sue Greenwald	Every Child Counts, First 5 Alameda County/ Children's Hospital Oakland Early Intervention Services
Jennifer Shallat	The Perinatal Council/ Brighter Beginnings	Sujata Bansal	Every Child Counts, First 5 Alameda County
Jill Ellis	Center for Early Intervention on Deafness	Mari Smith	Every Child Counts, First 5 Alameda County
Kate Warren	Family Resource Network	Suzanne Shenfil	City of Fremont Health and Human Services
Kayce Rane	Resource Development Associates	Iris Preece	City of Fremont Health and Human Services
Lynn Chung	Alameda County Public Health Department/ Maternal and Child Health	Barbara Garcia	Alameda County Developmental Disabilities Council

Alameda County Children's SART
Triage and Glue Workgroup

Name	Organization	Name	Organization
Anna Gruver	Every Child Counts, First 5 Alameda County	Reva Srinivasan	City of Fremont
Carol Brown	City of Berkeley Public Health Department	Ricki Shore	Alameda County Social Services/Children and Family Services
Elizabeth Ford	Every Child Counts, First 5 Alameda County	Rocio de mateo Smith	Area Board 5 on Developmental Disabilities
Jane Berzweig	Every Child Counts, First 5 Alameda County	Sonia Waters	Family Resource Network (Parent)
Kimberly Beckham	Family Paths	Sue Greenwald	Every Child Counts, First 5 Alameda County/ Children's Hospital Oakland Early Intervention Services
Laurie Soman	Lucile Packard Children's Hospital	Janis Burger	Every Child Counts, First 5 Alameda County
Lynn Chung	Alameda County Public Health Department/ Maternal and Child Health	Deborrah Bremond	Every Child Counts, First 5 Alameda County
Marge Deichman	Alameda County Public Health Department/ Family Health Services	Robert Ogilvie	Resource Development Associates
Megan Kirshbaum	Through the Looking Glass	Kayce Rane	Resource Development Associates
Nadiya Taylor	Child Care Planning Council		

Alameda County Children's SART
Assessment Services First Workgroup

Name	Organization	Name	Organization
Barbara Ivins	Children's Hospital Oakland/ Early Intervention Services	Julie Kurtz	KIDANGO
Christi Tuleja	Through the Looking Glass	Kathryn Orfirer	Children's Hospital Oakland Center for the Vulnerable Child
Deborrah Bremond	Every Child Counts, First 5 Alameda County	Kayce Rane	Resource Development Associates
Diana Kronstadt	Children's Hospital Center for the Vulnerable Child	Lisa Kleinbub	Regional Center of the East Bay
Dr. Lane Tanner	Children's Hospital - Division of Developmental and Behavioral Pediatrics	Margie Padilla	Alameda County Behavioral Health Care Services
Elizabeth Acosta Crocker	Children and Family Services Unity Council Head Start	Robert Ogilvie	Resource Development Associates

Felton Owens	Berkeley Unified School District	Suzanne Nelson	North Region SELPA
Iris Preece	City of Fremont Health and Human Services	Sue Greenwald	Every Child Counts, First 5 Alameda County/ Children's Hospital Oakland Early Intervention Services
Jan Tatarsky	Children's Hospital Oakland Neonatal Follow Up Program	Elizabeth Ford	Every Child Counts, First 5 Alameda County
Jill Ellis	Center for Early Intervention on Deafness	Janis Burger	Every Child Counts, First 5 Alameda County
Jill Rian	Alameda County Social Services/Children and Family Services		

Alameda County Children's SART Assessment Services Second Workgroup			
Name	Organization	Name	Organization
Julie Kurtz	KIDANGO	Barbara Ivins	Children's Hospital Oakland/Early Intervention Services
Suzanne Nelson	North Region SELPA	Dr. Renee Wachtel	Children's Hospital Oakland Division of Developmental and Behavioral Pediatrics
Diana Kronstadt	Children's Hospital Center for the Vulnerable Child	Dr. Lane Tanner	Children's Hospital - Division of Developmental and Behavioral Pediatrics
Christi Tuleja	Through the Looking Glass	Elizabeth Acosta Crocker	Children and Family Services Unity Council Head Start
Elizabeth Ford	Every Child Counts, First 5 Alameda County	Wanda Davis	Regional Center of the East Bay
Lynn Chung	Alameda County Public Health Department/ Maternal and Child Health	Sue Greenwald	Every Child Counts, First 5 Alameda County/ Children's Hospital Oakland Early Intervention Services
Deborrah Bremond	Every Child Counts, First 5 Alameda County		

Alameda County Children's SART Treatment Services and Community Support Workgroup			
Name	Organization	Name	Organization
Angie Garling	Local Planning Council	Maria Ramler	Every Child Counts, First 5 Alameda County
Barbara Bunn-McCullough	Perinatal Council/ Brighter Beginnngs	Marge Deichman	Alameda County Public Health Department/ Family Health Services
Carol Singer	Jewish Family and Children's Services	Megan Kirschbaum	Through the Looking Glass
Cherise Northcutt	Children's Hospital Oakland	Nishi Moonka	Resource Development Associates
Cynthia Rinker	Alameda County Social Services Children and Family Services	Pamm Shaw	Berkeley Albany YMCA
Deborrah Bremond	Every Child Counts, First 5 Alameda County	Patricia Bennett	Resource Development Associates
George Philipp	Every Child Counts, First 5 Alameda County	Rae Chapple	The Link to Children
Iris Preece	City of Fremont Health and Human Services	Robert Ogilvie	Resource Development Associates
Janis Burger	Every Child Counts, First 5 Alameda County	Sonia Waters	Family Resource Network
Kate Warren	Family Resource Network	Sue Greenwald	Every Child Counts, First 5 Alameda County/ Children's Hospital Oakland Early Intervention Services
Lynn Chung	Alameda County Public Health Department/ Maternal and Child Health		

Highlight - Four Year's of Mental Health Consultation to Child Care, 2003-2007

Children's increased risk for behavioral problems is often related to an increase in family stress and exposure to violence, maternal depression, hunger, etc. ECE providers often feel unsupported and lack appropriate training on social-emotional behavior. Therefore, it is not surprising to see preschool expulsion rates that are three times the expulsion rate of K-12 children (Gilliam, 2005).

ECC funded two cycles of 2-year grants (2003-2007) to 4-5 agencies for mental health consultation to ECE sites. Agencies were required to participate in intensive training and peer learning. Goals included: building leadership, development of a common language & standards for service delivery and building a system for mental health consultation to child care. Agencies also participated in the Partners in Collaboration program where a mental health professional is teamed with a mentor teacher to provide consultation to a classroom.

	2003-2004	2004-2005	2005-2006*	2006-2007*
Number of sites	35	36	25	26
Number of classrooms	89	90	94	82
Number of ECE staff	266	343	300	314
Number of children	1,882	2,005	1,472	1,435

*4 agencies provided services

Mental Health Consultation includes two main consultation components: classroom-based and child specific. Best-practice focuses on classroom-based consultation which builds the strengths of the teachers to use developmentally sound approaches to managing behavior and to identify children who require more individualized treatment. Over the partnership's four year period, classroom-based consultation increased from 38% to 68%.

The likelihood of expulsion decreases significantly with access to classroom-based behavioral consultation.

> **A child had repeated tantrums on the way to school and was labeled a "problem" child by his teacher. He was constantly shamed for his behavior and was threatened with expulsion if he didn't learn to behave. His family was confused, offended, and had difficulty receiving the negative feedback each week from his teacher. Although the child has difficulty regulating his emotions, our consultant determined that other factors were at work as well: his teacher's depression... and a general inability of staff to guide active boys.**

The child's teacher and the consultant worked together to prevent his expulsion.

> **Our consultant first established a relationship with his teacher so she could request help with the child...she allowed the consultant to "wonder with her" about contributors to the child's behavior. Through the reflective process they explored how he was getting negative attention at school and she began to give him some positive feedback after the consultant focused on his strengths...The family worked with the consultant on positive discipline strategies and how to become his advocate. The child is transitioning more smoothly from home to school without tantrums. Although challenges remain, he is still enrolled in school.**
>
> 2006-07 MH Partnership Report

A survey of teachers (33% response rate) in 2006 showed:

- **51% of teachers felt that consultation changed the way they think of children's emotional development; 72% reported that it changed the way they think about children's social development**
- **Directors felt the consultation experience provided a valuable resource to staff and was sensitive to the context of the site, parents and children**

Accomplishments of the mental health partnership included: bridging the gap between mental health and Early Care and Education; promoting standards of practice, increasing services; increasing professional development; demonstrating decreases in challenging behavior and increases in positive behavior; and changing proportion of classroom-based vs. child-specific services.

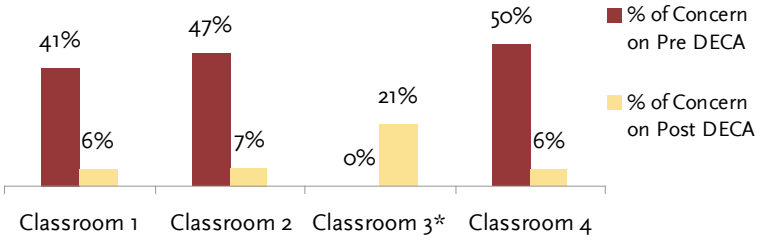
Partners in Collaboration

Partners in Collaboration (PIC) was a 12-month, cross-disciplinary training program that paired a mental health professional with an ECE professional (dyad). This year, four dyads were paired and spent three months building a relationship and discussing similarities and differences in their values, approaches and philosophy towards child care. The trained dyad worked jointly with a classroom teacher for nine months at four sites receiving MH consultation. The joint visits provided an integrated model of consultation leading to improved classroom outcomes. Surveys of PIC dyads and pre/post Devereux Early Childhood Assessments (DECA), a validated assessment of the perceived resilience of children in a classroom, were used to evaluate changes as a result of the PIC intervention.

WHAT WAS OUR IMPACT?

Teachers in four classrooms receiving PIC services completed DECAs on children in their classrooms at the beginning of the program and 6-7 months later.

2006-07 RESULTS OF PRE AND POST DECA ASSESSMENTS



*Classroom 3's initial problem-free DECA profile provided an opportunity for the PIC dyad and the teacher to think about whether the early observations were realistic. The classroom teacher became more reflective and had a more accurate assessment of the classroom on the post assessment.

Results from PIC dyad surveys revealed the impact of partnering with someone from another discipline:

> "I believe my partner and I have **incorporated each other's work into our own**. We are on the same page, no longer as separate in our two perspectives..."

> "It was wonderful to hear from the teacher's perspective. I had **no idea of** the **impact** we were making **in her classroom.**"

2006-07 PIC Survey

One teacher…described how working with the PIC dyad really helped her see the importance of **helping children build resiliency**… through everyday actions in the classroom. For example, "One boy had a hard time sitting during circle time... He asked everyday if he could go play with the blocks during circle time and I always told him 'no'. I realized that he was **taking initiative** by asking if he could play with blocks during circle time. So, the next time he asked, I said, 'thank you for asking and letting me know you would like to do something different'. I came up with a plan with my fellow teachers to allow him to do another activity during circle time [twice] a week. This plan really worked for my classroom and [made] a big difference in the boy."

2006-07 PIC report

Partnership Grants – Parent Child Developmental Playgroups (PCDP)

Young children identified with communication and social-emotional concerns are better prepared to enter pre-school/kindergarten by participating in developmental readiness playgroups. Few community-based settings currently exist where parents and children can engage in developmentally appropriate activities with the support of a child development specialist.

Three agencies participated in the second year of the parent-child developmental playgroup with on-site consultation and technical assistance by a lead agency. The goal of the PCDP partnership was to increase community capacity to provide developmentally enriching experiences and opportunities for parent-child interaction in a supportive environment. The playgroups were designed to meet the needs of children 2-5 years not in child care and who were identified at risk for developmental delay, but did not meet Regional Center or School District eligibility criteria for services. Each agency offered multiple play groups (grouped by language and ages of children) for a four- to six-month period. Children were referred to the playgroups primarily through friends, flyers, pediatricians' offices, community clinics or the Regional Center. Agencies planned playgroup activities that addressed gross motor development, fine motor development, language and communication, problem solving skills, personal-social development, sensory integration, transitions and the power of play. Agencies also helped parents navigate referrals when children needed further assessment and/or services.

Partnership members met bi-monthly to discuss specific topics and to reflect on the playgroup process. Trainings included: infusing speech and language in a playgroup setting, the special education system, community resources and referrals, sensory integration and temperament and language.

WHAT WAS OUR IMPACT?

PCDP trainings strengthened the partners.

> "We...[PCDP partners] **gained** a lot of **confidence and sharpen[ed] our skills** to do this work...have seen changes in the children and in their relationship with their parents. The training gave us the guidance and immediate feedback on how we are doing from week to week. [They are] a safe and nurturing environment to talk about our families and our challenges and to practice skills... We really enjoyed coming together with our cohort and sharing **and coming up [with solutions] as a group to solve common problems**. We have shifted our thinking from seeing our role as the "expert" to **working collaboratively with parents** in a process to have them gain insights on their own strengths and cultural resources to continue nurturing their children even after the group is over."
>
> 2006-07 Developmental Playgroup Partnership report

> "The trainings have helped our team evaluate **how cultural influences affect** our group **planning, assessment [and play]**... Along with being sensitive, aware and comfortable with other's cultures – we have **learned to better respond to** each **family's culture**... [It] has influenced our choice of words, our body language, our choice of songs and our play kit expectations. We have surveyed cultural foods, habits and family activities in order to design our activities and play kits to be attractive to both our English and Spanish households."
>
> 2006-07 Developmental Playgroup Partnership report

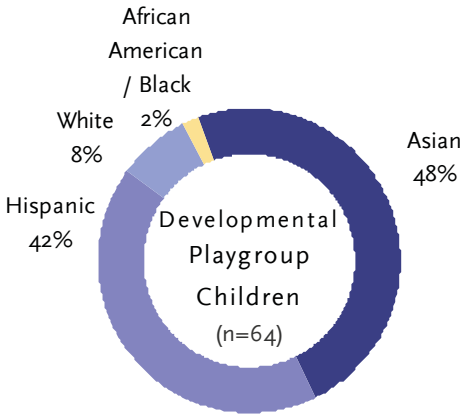
> There is **no model** of childcare and early intervention services **more effective** than one that envelopes and partners with parents/family...**There's no going back!**
>
> 2006-07 Developmental Playgroup Partnership report

62 children and 73 parents participated in the six-month developmental playgroups.

Playgroups were facilitated in Cantonese, Vietnamese, Spanish, English and bilingual Spanish/English.

An average of 10-15 play group sessions was attended by participating children and parents.

2006-07 RACE / ETHNICITY OF DEVELOPMENTAL PLAYGROUP CHILDREN



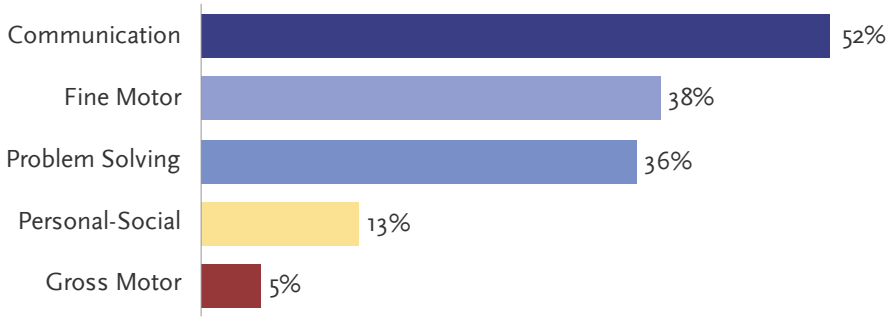
56 children from all three agencies were screened with the ASQ.

24 children were also screened with the ASQ-Social/Emotional. 38% were identified to be "of concern".

47 referrals were made to school districts, speech and language specialists, occupational and physical therapists, the Regional Center, dentists and Child Protective Services.

2006-07 PERCENT OF CHILDREN IN DEVELOPMENTAL PLAYGROUPS IDENTIFIED AS "OF CONCERN" ON ASQ

(n=60)



Results from a parent satisfaction survey showed that overall, parents who participated in the playgroups were extremely satisfied with the service. Some of them wished it occurred more frequently than once a week. Parents reported that they learned a lot and felt that the services were respectful of their culture and language. Most parents said they would recommend the playgroups to other families.

> "**What I like** about the program is that **it is conducted in my own native language** so I feel I could be a good role model for my child. My child is speaking more at home and we engage in mutual play and mutual conversation."
>
> 2006-07 PCDP Client satisfaction survey

> "The playgroups were **conducted in** their **primary home language** so that parents felt comfortable in conversing and scaffolding their child's speech and language skills. Parents no longer feel anxious about their child having to learn only English in order to succeed in pre-school. We reassured them that **children are able to learn two languages** and able to differentiate between the two when they speak to different audiences...
>
> 2006-07 PCDP Partnership report

> "The graduates of the programs are the ones most enthusiastic about spreading the word on this valuable resource that is not being offered elsewhere. This playgroup format is ... **more acceptable to the parents who do not want their child to be stigmatized** and labeled at such a young age."
>
> 2006-07 PCDP Partnership report

Early Childhood Mental Health: A Sound Investment for Alameda County

Presented by:
THE EARLY CHILDHOOD MENTAL HEALTH SYSTEMS WORKGROUP
August 2007

James

James is four-years old. He is acting out in school – hitting other children and throwing tantrums frequently.

His father is violent at home with James' mother. Lately, his mother has also been frustrated with James' behavior and is resorting to spanking and yelling in order to "get him in line."

James' teachers are also tired of his behavior in class and are considering expulsion . . .

Scientific Research

- *Children exposed to trauma exhibit: depression, anxiety, aggression, conduct problems, and defiant behavior.*
- *Early child abuse may result in irreversible damage to a child's brain.*

No Intervention for James' Family

James pre-school teachers spoke with his mother. His mother continued to address "James" problems with more yelling and spanking.

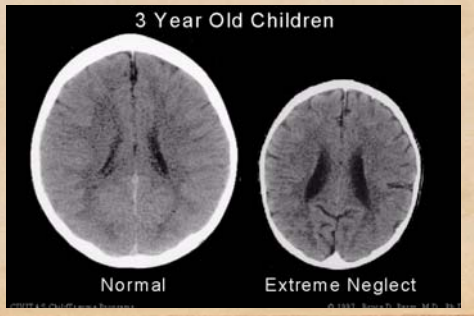
A month later, James was expelled from school; his mother had to quit her waitressing job. The lack of family income added more stress to the family and the violence worsened.

A visit from CPS a few months later found an extremely depressed mother and a neglected and abused James. He was removed from the house and placed in foster care.

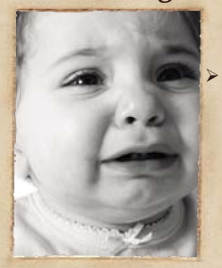
Short-term Impact of No Intervention

- *Poor attention in school and lower grades*
- *Pre-school expulsions - For every 133 pre kindergarten students in California, one is expelled. This is 3X the rate of expulsion in California k-12 schools.*
- *Increased parental stress and inability to cope with life challenges*
- *27.1% of the Alameda County child abuse referrals (substantiated) to Child Welfare Services were children birth to 5*

Early Abuse and Maltreatment Leads to Irreversible Damage



Long-Term Impacts



- Studies have also revealed a connection between exposure to violence and IQ suppression, a risk factor for juvenile delinquency.
- National studies on Juvenile Offenders, found 90% of juvenile detainees having experience with physical, emotional abuse, or witness to violence.

Significant birth-5 Population

- 121,000 children in Alameda County are ages 0-5.
- High incidences of predicting factors in the county .
- 27.1% of the Alameda County child abuse referrals (substantiated) to Child Welfare Services were children birth to 5.
- An OPD survey found that 85% of DV incidents had children, and of those, 63% had children under the age of five in the home.

Re-assessing Public Investment

Economists argue investment in early childhood education is optimal and a great return for investment.

Inversely, without early intervention programs, children fall through the cracks and may enter a costly foster care, special education, and/or juvenile system when older.

Federal Reserve Bank Economists: Early Childhood Good Investment

- *Economist's study $8 dollars for every $1 dollar invested in a child's early intervention program.*
- *The personal return for investment is in the form of higher wages later in life.*
- *The return for investment to society is up to 12% annually in increased productivity.*

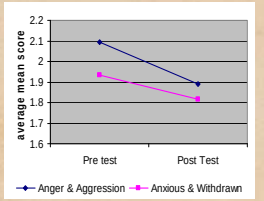
Costs of No Early Intervention

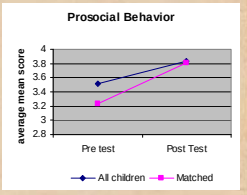
- *The costs of foster care placement per child annually to taxpayers is up to $144,000.*
- *The costs of special education per child annually is 1.5 to 4 times that of regular education.*
- *The annual cost of stay in CJJ per youth is $175,000/year. The average stay is 21.9 months = $319,375.*

Proven to Work Locally

- *Mental health consultation*
- *Preschool teacher training on social skills curriculum*
- *Parent-child mental health treatment*

Impact of Site-Based Services





- *Teachers rated children as showing reduced anger and aggression, and reduced anxious and withdrawn behavior*
- *Teachers also stated that children's pro-social behavior had improved significantly compared to before the program.*

Impact of Parent-Child Mental Heath Treatment

- *Focus of therapy is to promote and restore nurturing relationships between the primary caregiver and his or her child.*
- *A 2005 study at UCSF found that toddlers exposed to trauma who underwent parent-child therapy with their mothers experienced decreased behavior problems, and traumatic stress symptoms.*
- *Mothers also showed less symptoms of depression and general increased stability in relationship.*

Choices

Support for growth in language, motor skills, adaptive abilities and social-emotional functioning, = **success in school and contribution to society.**

OR

No support = **drop out of school, dependence on welfare benefit and commit crime – imposing significant cost on society**

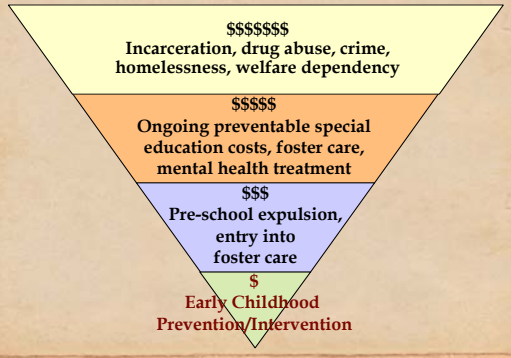
What Would You Rather Pay?

A. *The average stay in CJJ* **$319,375** *+ Recidivism Rates that bring about increased costs?*

OR

B. **$750** *per child for mental health consultation or $6,500 for Parent-Child mental health treatment proven to work?*

Increasing Financial and Social Costs



Investing in Early Childhood Intervention

1. *Mental Health Consultation to agencies and providers including early care and education, pediatric providers, community based agencies.*
2. *Increase in post graduate training to improve capacity for multi-cultural and bilingual providers. At present, it takes 3-6 months longer to hire a bilingual clinician in Alameda.*
3. *Universal screening for maternal depression.*
4. *Social Emotional Screening for young children with further assessment of children as needed.*
5. *Intervention/Treatment for children who are in stressed families who are themselves not showing symptoms.*

. . . And James?

Teachers contacted Carlos, the pre-school early childhood mental health consultant who provided support to his teachers to better understand and address James' behavior.

James and his family also met with a family therapist. James is now able to convey his fears and anxiety. The family is developing better ways to discipline and listen to James.

James is no longer fighting with his peers and is learning to "use his words" to convey his emotions.

James was not expelled and loves going to school. His teachers also love having him in school.

Early Childhood Mental Health Citations

1. Preschool Expulsion Rates in California and Alameda County (data source: "Pre-kindergarteners Left Behind: Expulsion Rates in State Pre-kindergarten Systems." W.S. Gilliam, May 4, 2005. Retrieved from www.nccp.org May 22, 2007
2. Preschool Expulsion Rates in California and Alameda County (data source: "Pre-kindergarteners Left Behind: Expulsion Rates in State Pre-kindergarten Systems." W.S. Gilliam, May 4, 2005. Retrieved from www.nccp.org May 22, 2007); The rate of expulsions is 7.5 per 1,000 enrolled at state-funded preschools. The k-12 grade expulsion rate in California is 2.5 per 1,000.
3. Source: http://cssr.berkeley.edu/CWSCMSreports/referrals/childCount/data/FR_AD_sep2006_1.html
4. Official citation: Perry, BD and Pollard, D. Altered brain development following global neglect in early childhood. Society For Neuroscience: Proceedings from Annual Meeting, New Orleans, 1997
5. Source: National Center for Mental Health and Juvenile Justice (NCMHJJ): "Trauma Among Youth in the Juvenile Justice System: Critical Issues and New Directions"; Julian D. Ford, Department of Psychiatry, University of Connecticut School of Medicine; John F. Chapman, Psy.D. State of Connecticut Judicial Branch, Court Support Services Division; Josephine Hawke, PhD, Department of Psychiatry, University of Connecticut School of Medicine; David Albert, PhD, Department of Psychiatry, university of Connecticut School of Medicine. June 2007. www.ncmhjj.com.
6. Source: National Center for Mental Health and Juvenile Justice (NCMHJJ): "Trauma Among Youth in the Juvenile Justice System: Critical Issues and New Directions"; Julian D. Ford, Department of Psychiatry, University of Connecticut School of Medicine; John F. Chapman, Psy.D. State of Connecticut Judicial Branch, Court Support Services Division; Josephine Hawke, PhD, Department of Psychiatry, University of Connecticut School of Medicine; David Albert, PhD, Department of Psychiatry, university of Connecticut School of Medicine. June 2007. www.ncmhjj.com.

Early Childhood Mental Health Citations

7. *Early Childhood Development on a Large Scale*, Rob Grunewald, Regional Economic Analyst Federal Reserve Bank of Minneapolis; Art Rolnick, Senior Vice President and Director of Research Federal Reserve Bank of Minneapolis, May 2005.
8. Melvin L. Burstein and Arthur J. Rolnick, "Congress Should End the Economic War Among the States," Federal Reserve Bank of Minneapolis Annual Report, *The Region 9* (March 1995).
9. Art Rolnick and Rob Grunewald, "Early Childhood Development: Economic Development with a High Public Return," *The Region* 17 (December 2003 Supplement). (PDF)
10. Early Childhood Development on a Large Scale, Rob Grunewald, Regional Economic Analyst Federal Reserve Bank of Minneapolis; Art Rolnick, Senior Vice President and Director of Research Federal Reserve Bank of Minneapolis, May 2005
11. Alameda County Social Services Agency, Quality of Life Benchmarks Report 2000.
(5) California Department of Corrections and Rehabilitation. (2007). *Summary fact sheet.* Retrieve on April 23, 2007 from http://www.cdcr.ca.gov/ReportsResearch/summarys.html
12. 2005 Toward Evidence-Based Treatment: Child–Parent Psychotherapy with Preschoolers Exposed to Marital Violence Alicia F. Lieberman, Ph.D., Patricia Van Horn, J.D., Ph.D., And Chandra Ghosh Ippen, Ph.D. 20 Seibel, N.L., Farlakian, R., and Perez, A. (in press). 3rd revision.
13. Rob Grunewald, Regional Economic Analyst Federal Reserve Bank of Minneapolis; Art Rolnich, Senior Vice President and Director of Research Federal Reserve Bank of Minneapolis; Early Childhood Development on a Large Scale.)

Mental Health Services Act
Prevention & Early Intervention

COMMUNITY REPORT EXECUTIVE SUMMARY COVERSHEET

Instructions:
1. Please use this form as a cover to any report you want to submit for review by the PEI Planning Panels.
2. Email this completed form and an electronic version of your report (Word document or PDF) to mhsa@acbhcs.org no later than December 14, 2007.

Organization* (if applicable): Alameda County Health Care Services Agency, School Health Services Coalition
Contact Person: Yvette Leung, Director, School Health Services
Address: 1000 San Leandro Blvd., Suite 300, San Leandro, CA 94577
Phone No./ Email address: (510) 667-7991 | yvette.leung@acgov.org

Please attach a list of all groups and organizations that contributed to this report.

What age group does your organization serve or represent?

☑Children & Youth (0-18) ☑Transition Age Youth (14-25) ❒ Adults (18-59) ❒ Older Adults (60+)

Under each category, choose the item your report PRIMARILY addresses:

Key Community Mental Health Needs

❒ Disparities in Access to Mental Health Services
❒ Psycho-Social Impact of Trauma
☑At-Risk Children, Youth and Young Adult Populations
❒ Stigma and Discrimination
❒ Suicide Risk

Priority Populations

❒ Underserved Cultural Populations
❒ Individuals Experiencing Onset of Serious Psychiatric Illness
☑Children/Youth in Stressed Families
❒ Trauma-Exposed
☑Children/Youth at Risk for School Failure
☑Children and Youth at Risk of Juvenile Justice Involvement

For more detailed explanations of the terms above, please review the PEI Program & Expenditure Guidelines available at http://www.dmh.ca.gov/Prop_63/MHSA/Prevention_and_Early_Intervention/default.asp

ALAMEDA COUNTY SCHOOL HEALTH SERVICES EXECUTIVE SUMMARY

SECTION I - ORGANIZATIONAL BACKGROUND:

Alameda County Health Care Services Agency (HCSA) oversees the OUR KIDS Programs, allocating Tobacco Master Settlement, Measure A Funds and managing Oakland Unified School District (OUSD) and City of Oakland Measure Y funds that contribute toward 19-21 FTE Clinical Case Managers at 30 schools in 3 school districts. Additionally, HCSA provides oversight, administration and technical assistance for 11 school-based health centers (SBHCs) and 3 coordinated school health programs in 7 school districts and is working in partnership with 4 cities to plan for adolescent health services in Alameda County. HCSA also convenes the Regional Advisory Committee of School-Based Behavioral Health Services, a subcommittee of the Alameda County School Health Services Coalition (SHSC), comprised of Alameda County Behavioral Health Care Services, Alameda County Probation Department, Social Services, Berkeley, Fremont, Hayward, Oakland and San Lorenzo Unified School Districts, City of Oakland, community mental health providers and Supervisor Gail Steele's Office to make systems-level change toward improving behavioral health status of youth in schools. Since January 2006, the SHSC began to formulate a vernacular that clearly described the mental health needs and priorities for children and youth in schools to leverage Mental Health Services Act (MHSA) Prevention and Early Intervention (PEI) funding.

In September 2007, SHSC staff began talks with a broader base of county stakeholders to tease out how PEI resources might help to create a comprehensive mental health care continuum for children and youth in Alameda County. This broader stakeholder group includes the member organizations of SHSC, OUSD's Mental Health Integration Partnership, Alameda County Early Childhood Mental Health Planning Committee, Huskey Group, Children and Family Service Network and the Children's Advisory Committee. Together these groups have developed one overarching framework and a set of core principles to ensure a continuum of specific developmental and age appropriate services for children and youth ages 0-24 years.

SHSC has its base of strength and expertise in fostering health and wellness services for children and youth in school through our member agencies, programs, and mental health provider partners. Many of these youth are at risk for poor academic, physical and mental health outcomes due to a lack of environmental protective factors. SHSC has developed its SHSC PEI Plan with recommendations that employ evidenced based strategies to address the Key PEI Community Mental Health Needs of **At-Risk Children, Youth and Young Adult Populations.** SHSC will focus on children and youth in school (K-12) that fall into the following three PEI priority populations: 1) **Children and youth in stressed families** (strategies focus on children and youth in families where parental conditions place their children at high risk of behavioral and emotional problems); 2) **Children and youth at risk for school failure ;** and 3) **Children and youth at risk of juvenile justice involvement** (strategies address risk factors for delinquent behavior among children and youth).

SECTION II - DATA SOURCES:

Supporting data for the recommendations put forward by the Alameda County School Health Services Coalition were derived from an extensive literature review of evidenced based models and best practices in mental health care for children and adolescents. The data in support of our findings and recommendations came primarily from two sources: 1) Published data on mental health indicators for school-aged youth and school-based mental health best practices; and 2) Strategic planning discussions with experts in the school-based mental health field in Alameda County. Specifically, the data and information represent:

- Published data on mental health indicators for school-aged youth and school-based mental health best practices. "Researchers supported by the National Institute of Mental Health (NIMH) have found that half of all lifetime cases of mental illness begin by age 14 and that despite effective treatments, there are long delays — sometimes decades — between first onset of symptoms and when people seek and receive treatment. This study also revealed that an untreated mental disorder can lead to a more severe, more difficult to treat illness, and to the development of co-occurring mental illnesses.[1]" According to the Surgeon's General Report on

[1] National Institute of Mental Health. Mental Illness Exacts Heavy Toll, Beginning in Youth (2005). Accessed on December 5, 2007: http://www.nimh.nih.gov/science-news/2005/mental-illness-exacts-heavy-toll-beginning-in-youth.shtml.

Mental Health (1999), schools are one of the "major settings for the potential recognition of mental disorders in children and adolescents, yet trained staff are limited, as are options for referral to specialty care"[2]. There is a wealth of subsequent research in support of the school setting as an effective venue for providing effective mental health services to youth. This published data is cited throughout this proposal.

- Strategic planning discussions with school-based mental health providers, school staff and administrators, key policymakers and other stakeholders in Alameda County were held throughout the 2006/07 fiscal years. These discussions culminated in a brainstorming and planning sessions of the SHSC that was attended by over 30 individuals representing various County offices, educational institutions, and community-based mental health organizations who have had decades of experience serving youth and their families in the school setting. These discussions identified the gaps in current service delivery systems, successes and challenges in service delivery, and best practices and effective strategies to serve the mental health needs of school age youth and their families in schools. Findings from these discussions are integrated into the content of this proposal.

SECTION III - RECOMMENDATIONS: (See Attachment 1: *Recommended Strategies and Approaches for the Use of Prevention and Early Intervention Funding to Improve Outcomes for Alameda County Children and Youth*)

Growing evidence shows that school mental health programs improve educational outcomes by decreasing absences, decreasing discipline referrals, and improving test scores.[3] The key to improving academic achievement and reducing the potential for school failure is to identify mental health problems early and, when needed, provide appropriate support services or links to services. Prevention approaches based on building youth assets— positive factors that have been found to be important in promoting young people's healthy development—have been shown to positively impact school success and reduce the likelihood of youth engaging in risk behaviors.

Each year the OUR KIDS Program provides nearly 15,000 behavioral health visits to nearly 1,000 students and SBHCs provide nearly 7,000 behavioral health visits to over 1,000 students. Over 350 students participate in youth development programs run through the SHSC. Of the 9th and 11th grade students who had used the SBHC for behavioral health services 83% said the SBHC helped them deal better with personal and family issues. Likewise, 83% of SBHC youth program participants said that they feel they have more control over their future as a result of their participation in the program. These important outcomes are significantly enhanced when programs and services are culturally appropriate and include family centered intervention.

Healthy child development requires strong nurturing families that in turn are nurtured and supported by individuals and institutions within the community.[4] The field of family support has shown that efforts that are truly supportive view families from a strengths-based perspective, are responsive to their needs and interests, and empower parents to act on their own and their children's behalf.[5] Program evaluations point to support and service provision as one way to engage families in their children's learning.[6] According to Knitzer and colleagues (1993), family participation promotes four changes in the way children are served: increased focus on families; provision of services in natural settings; greater cultural sensitivity; and a community-based system of care.

Only 16% of all children receive any mental health services. Of those receiving care, 70%-80% receive that care in a school setting.[7] Research finds that schools are the perfect place for the delivery of mental health prevention and early intervention efforts, noting that when children do receive mental health services, it is most likely to occur not in the

[2] U.S. Department of Health and Human Services. *Mental Health: A Report of the Surgeon General—Executive Summary*. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health, 1999.

[3] Jennings, J., Pearson, G., & Harris, M. (2000). Implementing and maintaining school-based mental health services in a large, urban school district. Journal of School Health, 70, 201-205.

[4] Weiss, H. B., Woodrum, A., Lopez, M. E., & Kraemer, J. (1993). Building villages to raise our children: From programs to service. Cambridge, MA: Harvard Family Research Project.

[5] Dunst, C. (1995). Key characteristics and features of community-based family support programs. Chicago: The Family Research Coalition of America.

[6] Harris & Wimer, 2004; U.S. Department of Education. (2000). Working for children and families: Safe and smart after-school programs. Washington, DC: U.S. Department of Education.

[7] Rones M and Hoagwood K. School-Based Mental Health Services: A Research Review. Clinical Child & Family Psychology Review, Vol. 3, No. 4, 2000: 223-241. Burns BJ, Costello EJ, Angold A, Tweed D et al. Children's Mental Health Service Use Across Service Sectors, Health Affairs, Vol. 14, No. 3, 1995: 149-159.

specialty mental health sector but in public schools.[8] Research has suggested that schools may function as the de facto mental health system for many children and adolescents. Not only can schools serve as critical settings in which children's behavioral health needs are first identified, but schools also can facilitate access to and delivery of mental health services and behavioral interventions. The evidence-based strategies and promising practices recommended by SHSC simultaneously reach Children and Youth in Stressed Families, Children and Youth at Risk for School Failure, and Children and Youth at Risk of Juvenile Justice Involvement).

SHSC recommends establishing a continuum for the delivery of culturally competent school-based support services for school-age youth and their families as a preventative measure against future mental illness. This continuum would necessitate greater coordination between school systems and mental health care delivery systems to support schools as the ideal place to establish a variety of mental health support services that are easy to access, available to all students and their families, and require no indication or diagnosis of mental distress.

The prevention strategies detailed in the SHSC PEI Plan will deliver:

- **Youth:** Innovative broad-based peer education, youth support groups, and individual counseling & case management in schools to build protective factors and skills.
- **Families:** Family education, consultation and support groups, coupled with guided referral and case management for families in the home and at the school. Family services would be coordinated with the child's support plan to help build protective factors in the home environment and strengthen the child's resiliency.
- **Schools:** Training for school staff to promote early identification of mental distress, mental health consultation to expand staff capacity to provide support to students and families, and new infrastructure in schools to improve learning supports.

The overarching strategy for mental health early intervention provides a variety of 6- 12 month low intensity intervention services in schools for students at-risk for school failure and their families to reduce the potential of future mental illness and future involvement with juvenile justice agencies.

Recommended early intervention strategies detailed in the SHSC PEI Plan will deliver:

- **Youth**: Youth support groups, and individual counseling, coaching, crisis intervention and case management.
- **Families:** Family support groups and counseling, consultation, parenting education, referral and case management in the home and school.
- **Schools:** Training and mental health consultation for alternative education school staff and creation of systems-level warm handoffs to identify students at-risk for mental illness and involvement with juvenile justice and provide support services.

Combined, SHSC PEI recommendations are targeted to achieve the following outcomes:
Individuals and Families:

- Increased knowledge of social, emotional, and behavioral issues
- Enhanced resilience and protective factors
- Improved parenting knowledge and skills
- Increased prosocial behaviors associated with school-related outcomes (e.g., academic skills and attending school without being suspended, dropping out, or being expelled).
- Reduced involvement with law enforcement and courts

School Program and System Outcomes:

- Increase in number of individuals/families from underserved populations who receive PEI services
- Increase in number of organizations with a formal process for identifying individuals/families with social, emotional, and behavioral issues
- Increased access to evidence-based mental health services by children and their families

Long-Term Community Outcomes: Improved mental health status among underserved youth populations

[8] Rones & Hoagwood, 2000; U.S. Department of Health and Human Services, 1999, 2001

Recommended Strategies and Approaches for the Use of Prevention and Early Intervention Funding to Improve Outcomes for Alameda County Children and Youth

Founded in 1996, and sponsored by Alameda County Health Care Services Agency, the Alameda County School Health Services Coalition (formerly School-Based Health Center Coalition) provides an array of technical assistance and support to strengthen the capacity of existing school health programs and to expand the delivery of health and wellness programs in schools throughout Alameda County. The Coalition represents a cross-disciplined stakeholder group, including practitioners, school and school district administrators, advocates, and policy makers, dedicated to improving the health of youth. Coalition members reflect the diversity of Alameda County communities, particularly the cultural and ethnic diversity of the student populations that it serves.

As described in the School-Based Strategy Executive Summary, extensive research has demonstrated that prevention and early intervention approaches that promote positive youth development and identify and address mental health problems in the school setting lead to improved social, behavioral and educational outcomes for youth. In 2007, the Alameda County School Health Services Coalition (SHSC) formed a subcommittee called the Regional Advisory Committee of School-Based Behavioral Health Services to advocate for systems-level change toward improving behavioral health status of youth in schools. With representatives from Alameda County Behavioral Health Care Services, Alameda County Probation Department, Social Services, Berkeley, Fremont, Hayward, Oakland and San Lorenzo Unified School Districts, City of Oakland, community mental health providers and Supervisor Gail Steele's Office, the Regional Advisory Committee's main function is to provide cross-system policy and program support to achieve this goal.

Understanding the complexity and difference in the need, scope, and delivery of prevention and early intervention services, SHSC continues to work collaboratively with other providers of youth and children's services to create a holistic culturally responsive vision and develop sound implementation strategies. This collaboration has lead to an articulation of core principles by which we and our collaborative partners agree to uphold as we work individually and collectively to create a comprehensive developmental and age appropriate mental health care continuum for children and youth ages 0-24.

The six core principles are:

1. Create a comprehensive mental health care continuum that ensures access to prevention and early intervention services for the individual, family, and community as a whole organism.
2. Strengthen the effectiveness of the existing mental health care delivery system by improving coordination between health screening, assessment, and referral.
3. Provide mental health consultation to non-mental health personnel who have constant interaction with children and youth and their families.
4. Develop place-based interventions in diverse natural settings where children, youth and families congregate, including childcare, primary care, schools, and juvenile detention settings.
5. Standardize the use of evidenced based tools and approaches to more efficiently recognize, screen, assess, and link trauma exposed children and youth to critical support services in a timely manner.
6. Utilize the power of peer and family relationships and peer/family led support groups to coach individuals and families who are impacted by mental distress

For over a decade, SHSC has partnered with the University of California, San Francisco Institute for Health Policy Studies (UCSF) to conduct an ongoing comprehensive evaluation of the various SHSC programs to demonstrate the impact of these programs on youth in Alameda County. The Mental Health Services Act, Prevention and Early Intervention (PEI) funding has provided SHSC with a unique opportunity to advance its efforts to improve systems of care in schools and in doing significantly improve health and academic outcomes for children and youth in this county. SHSC evaluation considerations for existing services and proposed PEI strategies and recommendations examine the following hypotheses:

- Provision of school-based mental health services will lead to improved social and health outcomes of youth, including increased protective factors, such as connections to caring adults and positive coping strategies, decreased risk behaviors, such as substance use and engaging in violent activities, and alleviate, lessen or eliminate the onset of mental illness.
- Implementation of school-based counseling interventions focused on improving academic behaviors will lead to improved attitudes toward educational attainment and academic outcomes, such as grades and attendance.

Current SHSC mental health services evaluation data has demonstrated the need for and successes of existing interventions over time, for example:

- Youth researchers in Berkeley partnering with the UCSF researchers and school-based health center staff at their school found that that 22% of the students they surveyed reported having thought about death or suicide in the past two weeks. These students were also more likely than their peers who did not report having these thoughts to show many more signs of depression, including having a hard time trusting people and feeling negatively about their grades, like they did not fit in at school, and that their lives were not always worth living. Based on these findings, the youth researchers recommended that the school and health center integrate screening and counseling for depression into all services for youth at their school; implement a "Community Education Campaign about teen depression because there is a lot of stigma about depression both in school and in the community," and educate teachers and other school staff on recognizing the signs of depression.

- School staff reported being very supportive of the OUR KIDS behavioral health program for elementary and middle school students. Nearly all school staff survey respondents (84%) felt that students at their school needed the services "a great deal." The majority of school staff reported numerous benefits of the Our Kids program, including acting as a referral resource (80%), providing support for parents/families (78%); improving student behavior (77%); and providing students with a safe place to go (71%).

- Twelve elementary students identified as high risk participated in an intensive summer program through OUR KIDS, which focused on teaching youth coping skills, dealing with aggression and engaging in positive social interactions. This program was very successful, with all of the participants' parents expressing satisfaction with the impact of these services on their children, particularly in helping them learn how to express themselves in healthy ways and control their aggression and other negative behaviors, and suggesting that the program be available to more youth.

The demonstrated successes of the SHSC initiatives support the concept that schools are an effective setting to identify mental health needs of youth and provide interventions to minimize the development of mental health illnesses in adulthood. Based on our experience in providing school-based mental health services and an analysis of existing services and gaps, the SHSC has drafted a plan of specific evidence based practices (EBP) that are recommended for use in our PEI strategy. These EBPs were determined during two recent strategic planning meetings with SHSC provider partners facilitated by the SHSC evaluator and by analyzing information drawn largely from the PEI resource materials. Identification of appropriate EBPs were based on several factors, including but not limited to selecting practices that:

- Complement existing school-based interventions targeting prevention and early intervention needs of school-based youth, including violence prevention curricula;
- Address the individual and family factors and systems that both support and impact the healthy development of youth;
- Work in partnership with schools and do not burden school staff who already have many demands on their time during the school day;
- Promote a positive school climate and culture that helps build protective factors
- Incorporate principles of learning support systems
- Demonstrated measurable outcomes with populations that are as diverse as Alameda County.
- Complement the strategies proposed by other planning groups targeting school-aged youth, in particular the Children's Advisory Committee of the Mental Health Board, which is addressing elementary school aged youth exposed to trauma. Our proposed strategy for elementary aged children addresses other needs of this age group in complement to the CAC proposed trauma focused strategy.

Overview of SHSC Selected Evidence Based Practices by Focus Area

Focus Area: Youth

- *Teen Screen*
- *Integrated Primary Care and Mental Health Services*
- *Aggression Replacement Training*
- *Gang Resistance is Paramount (GRIP)*
- *Cognitive Behavioral Interventions for Trauma in Schools*
- *Reconnecting Youth (*resiliency building curriculum for middle and high school

Focus Area: Families

- *Strengthening Families Program*

Focus Area: Schools and School Systems

- *Professional Development on Identifying Students with Mental Health Needs*
    - Train school staff on recognizing mental health symptoms, suicide risk, etc.
    - Professional Development for school staff on specific mental health issues
    - Trauma Response Trainings and Protocols
    - Train staff on making referrals and coordinating with mental health providers, etc.

- *Red Flags Curriculum for Middle School Level*
- *After School Education and Safety Programs (ASES)*

It is important to note that the attached table details *suggested* strategies, yet the strategic planning partners felt strongly that implementation of the proposed strategies must include collaborative planning with behavioral health providers/agencies, the school districts and sites, and school-based health centers and providers to be most effective. Furthermore, one significant component is missing from this list of suggested practices – that of peer leadership, provider/educator, and support group programs. Our work in the SHSC has proven that this is an effective method to empower and educate youth that results in significant outcomes, as also supported in adolescent health literature. A best practice model was not identified in this timeframe but ideally would be included in any future implementation plans.

In closing, implementation of the proposed strategies would necessarily include BHCS developing collaborative plans with the school districts, school sites, and with health care centers. Respective organizational roles, responsibilities and resources and likely affect on school and health center operations would need to be fully understood by collaborative partners prior to implementation.

Please see Addendum A: Suggested Prevention and Early Intervention Strategies & Approaches

Addendum A: Suggested Prevention and Early Intervention Strategies & Approaches
Prepared by the Alameda County School Health Services Coalition, MHSA, PEI School-Based Workgroup

Program Name	P/ EI/ Systems			Priority Population			Setting				Description	Anticipated Outcomes
	Preven-tion	Early Inter-vention	Systems	C/Y in Stressed Families	C/Y at Risk of Juv Just	C/Y Risk of School Failure	ES	MS	HS	Other		Individual & Family Outcomes | Systems Outcomes
Cognitive Behavioral Interventions for Trauma in Schools (CBITS)		X				X	X	X			CBITS is a collaborative project with the Los Angeles School District (LAUSD), provides mental health screening and a standardized brief cognitive behavioral therapy treatment in schools for students who have been exposed to violence. Used with 8 -15 year olds.	Increased protective factors; reduced risk factors; lower PTS and depressive symptoms; lower psych dysfunction
Integrated Primary Care and Mental Health Services	X	X		X				X	X	X	Multidisciplinary team with behavioral health specialists embedded in services: • Promotion of optimal mental health for everyone; • Universal voluntary screening of all individuals or if indicated; • Early intervention, if appropriate (support groups, classes, etc.); • Behavioral health assessment and referral, if necessary: • Brief psychotherapy, counseling less than one year	Increased identification and referral; increased knowledge of social, emotional and behavioral issues; improved mental health status; increased social support; increased appropriate health seeking
Professional Development	X	X	X	X	X	X	X	X	X		Capacity building for teachers and school staff to identify and address potential mental health needs of students and their families.	Improved process for identifying individuals/ families with social, emotional, and behavioral issues; Increased number of ind/ families identified as needing services; Increased number of ind/ families receiving services

Program Name	P/ EI/ Systems			Priority Population			Setting				Description	Anticipated Outcomes
	Preven-tion	Early Inter-vention	Systems	C/Y in Stressed Families	C/Y at Risk of Juv Just	C/Y Risk of School Failure	ES	MS	HS	Other		Individual & Family Outcomes | Systems Outcomes
Reconnecting Youth		X				X			X		Curriculum teaches skills to build resiliency with respect to risk factors and to moderate early signs of substance abuse, and depression/aggression. The program incorporates social support and life skills training.	Decreased substance use; Reduced risk factors; Improved protective factors; Improved grades and school attendance; Decreased emotional distress; Increased self-esteem, personal control, prosocial peer bonding, and social support
Red Flags	X					X		X			Designed to help students, parents, and school staff members recognize and respond to signs of depression and related mental health illness.	Increased knowledge of clinical depression; Increased referrals; Increased number of individuals receiving services
Strengthening Families Program		X		X	X	X	X	X	X		SFP is an evidence-based family skills training program found to significantly reduce problem behaviors, delinquency, and alcohol and drug abuse in children and to improve social competencies and school performance. Used with families of 3-17 year olds, the program provides life and social skills trining for individuals, parenting skills development through familiy and peer sessions; the familiy is engaged as a whole to streghten family bonding and build positive communication skills. The curriculum is available in spanish and has been modified for use with African American and Asian/Pacific Islander families.	Reduced risk factors; Increased protective factors; Decreased substance use; Increased use of parenting skills

Program Name	P/ EI/ Systems			Priority Population			Setting				Description	Anticipated Outcomes
	Preven-tion	Early Inter-vention	Systems	C/Y in Stressed Families	C/Y at Risk of Juv Just	C/Y Risk of School Failure	ES	MS	HS	Other		Individual & Family Outcomes | Systems Outcomes
Teen Screen		**X**				**X**		**X**	**X**		Voluntary school screening to identify youth who are at-risk for suicide and potentially suffering from mental illness.	Identification of students contemplating suicide and/or suffering from depression
Aggression Replacement Training (ART)		**X**			**X**			**X**	**X**		ART is a multimodal psychoeducational intervention designed to alter the behavior of chronically aggressive adolescents and young children. The goal of ART® is to improve social skill competence, anger control, and moral reasoning. The program incorporates three specific interventions: skill-streaming, anger-control training, and training in moral reasoning. The program consists of a 10-week, 30-hour intervention administered to groups of 8 to 12 juvenile offenders thrice weekly. The 10-week sequence is the "core" curriculum, though the ART® curriculum has been offered in a variety of lengths. During these 10 weeks, participating youths typically attend three 1-hour sessions per week, one session each of skill-streaming, anger-control training, and training in moral reasoning. Used with 12-17 year olds.	Enhanced prosocial skill competency and overt prosocial behavior: Reduced levels of rated impulsiveness; Decreased frequency and intensity of acting-out behaviors; Enhanced levels of moral reasoning

Program Name	P/ EI/ Systems			Priority Population			Setting				Description	Anticipated Outcomes
	Preven-tion	Early Inter-vention	Systems	C/Y in Stressed Families	C/Y at Risk of Juv Just	C/Y Risk of School Failure	ES	MS	HS	Other		Individual & Family Outcomes | Systems Outcomes
Gang Resitance is Paramount (GRIP)	X				X		X	X	X		GRIP began in 1982 in an attempt to curb gang membership and discourage future gang involvement in Paramount, Calif. The program's objectives are to educate students about the dangers of gangs, discourage the city's youth from joining gangs, educate the students' parents about the signs of gang involvement, and provide parents with the resources that will help them eliminate gang activities in their homes and neighborhoods. GRIP staff are familiar with gang activity, but avoided gang involvement.	Increased self esteem; Negative attitudes about gang involvement; Low levels of gang involvement in participants over time
After School Education and Safety (ASES)	X		X	X	X	X	X	X			ASES creates partnerships between schools and local community resources to provide literacy, academic enrichment, and safe constructive alternatives for students in grades K-9. MHSA funds can be used to support mental health activities in the ASES local after school education and enrichment programs. ASES programs operate as collaboratives. MHSA, PEI activities in communities implementing ASES programs would build upon existing local collaboratives and use proven strategies to provide a unified, integrated support system for children and youth.	Embedding mental health pervention activities in ASES programs would offer a universal strategy for service system enhancements to coordinate mental health programs and interventions with a broader base of school enrichment activities .

COMMUNITY REPORT EXECUTIVE SUMMARY COVERSHEET

Instructions:

1. Please use this form as a cover to any report you want to submit for review by the PEI Planning Panels.
2. Email this completed form and an electronic version of your report (Word document or PDF) to mhsa@acbhcs.org no later than December 14, 2007.

Organization* (if applicable): Alameda County Health Care Services Agency, School Health Services Coalition
Contact Person: Yvette Leung, Director, School Health Services
Address: 1000 San Leandro Blvd., Suite 300, San Leandro, CA 94577
Phone No./ Email address: (510) 667-7991 | yvette.leung@acgov.org

Please attach a list of all groups and organizations that contributed to this report.

What age group does your organization serve or represent?

- ☑ Children & Youth (0-18)
- ☑ Transition Age Youth (14-25)
- ❒ Adults (18-59)
- ❒ Older Adults (60+)

Under each category, choose the item your report PRIMARILY addresses:

Key Community Mental Health Needs

- ❒ Disparities in Access to Mental Health Services
- ❒ Psycho-Social Impact of Trauma
- ☑ At-Risk Children, Youth and Young Adult Populations
- ❒ Stigma and Discrimination
- ☑ Suicide Risk

Priority Populations

- ❒ Underserved Cultural Populations
- ❒ Individuals Experiencing Onset of Serious Psychiatric Illness
- ☑ Children/Youth in Stressed Families
- ❒ Trauma-Exposed
- ☑ Children/Youth at Risk for School Failure
- ☑ Children and Youth at Risk of Juvenile Justice Involvement

For more detailed explanations of the terms above, please review the PEI Program & Expenditure Guidelines available at http://www.dmh.ca.gov/Prop_63/MHSA/Prevention_and_Early_Intervention/default.asp

ALAMEDA COUNTY SCHOOL HEALTH SERVICES COALITION
SPECIAL PEI YOUTH SUICIDE PREVENTION EXECUTIVE SUMMARY

SECTION I - ORGANIZATIONAL BACKGROUND:

Alameda County Health Care Services Agency (HCSA), under the auspices of the School Health Services Coalition (SHSC), provides oversight, administration and technical assistance for several county-wide school health initiatives, including the OUR KIDS Program that provides 19-21 FTE Clinical Case Managers at 30 schools in 3 school districts; the School-Based Health Center (SBHC) Coalition, comprised of 11 SBHCs that provide comprehensive medical, mental health, health education and youth development services; and 3 coordinated school health programs in 7 school districts. Additionally, SHSC is working in partnership with 4 cities (Livermore, Fremont, Dublin, and Pleasanton) to plan for adolescent health services. To support this work, HCSA convenes the Regional Advisory Committee of School-Based Behavioral Health Services, a subcommittee of the SHSC, to make systems-level change toward improving behavioral health status of youth in schools. The subcommittee is comprised of representatives from Alameda County Behavioral Health Care Services, Probation Department, and Social Services; Berkeley, Fremont, Hayward, Oakland and San Lorenzo Unified School Districts; City of Oakland; community mental health providers; and Supervisor Gail Steele's Office.

The SHSC believes in a genuine needs assessment process that involves students, parents, school staff and other key stakeholders in understanding the health needs of a school community and informing programming to address these needs. As such, working in partnership with the City of Fremont and Fremont Unified School District, SHSC launched the Fremont Adolescent School Health Initiative (FASHI) to promote the positive development of youth and young adults in Fremont and reduce health barriers to learning by developing a coordinated school health program that increases access to and utilization of comprehensive, quality adolescent health and wellness services. FASHI supported a team of Fremont students in forming S.P.A.R.K.S. (Stand Powerfully And Reach Kids Successfully to conduct a youth-led health and wellness assessment. Similarly, SHSC worked with the schools and school districts in Dublin, Livermore, and Pleasanton to establish the Tri-Valley Youth Planning Board (YPB). YPB is a group of youth who led a regional adolescent needs assessment to identify and address major health concerns for youth in the Tri-Valley area. Formed in Fall 2005, the YPB has engaged a total of 29 representatives from grades 8 through 12, from Las Positas Community College, and from all three Tri-Valley cities.

On December 4, 2007, members of the YPB spoke at the PEI Community Input Meeting in Livermore. Moved by the YPB students' remarks, the SHSC was asked to submit a proposal for the use of Mental Health Services Act (MHSA) Prevention and Early Intervention (PEI) funding to eliminate or substantially reduce the number of suicides and attempted suicides among youth in Alameda County.

SECTION II - DATA SOURCES:

Supporting data for the recommendations put forward by the SHSC were derived from an extensive review of published data, student/parent/school staff survey, interview and focus group data, and evidenced-based youth suicide prevention models.

- **City and county data:** Existing city and county specific data was compiled from a variety of sources including: California Healthy Kids Survey, Youth Health and Wellness in Alameda County Report, and vital statistics data.
- **Published data on mental health and suicide prevention best practices**. National data indicates that 17% of high school students have seriously considered suicide and that nearly 9% have attempted suicide[1]. There is a wealth of subsequent research in support of the school setting as an effective venue for raising awareness and screening for suicide risk among youth. This published data is cited throughout this proposal.
- **Student/parent/school staff survey, interview and focus group data:** Over the last few school years, several youth-led research efforts have been conducted to obtain further data on student health needs in Alameda County. This proposal provides a synopsis of the common findings and recommendations of these youth-driven health and wellness needs assessments, which are a key part of county-wide school health services planning that the SHSC supports. The full reports from these projects are attached for the Planning Panel's reference. These efforts include:

[1] Alameda County School Health Services Coalition and Public Health Department. (2006). Youth Health and Wellness in Alameda County.

- *Tri-Valley Youth Planning Board research projects*, including the Tri-Valley Student Health Survey , Tri-Valley Focus Groups, and Regional Youth Summit. A total of 4, 265 high school student surveys were completed and 30 high school students from continuation schools and 25 parents participated in a series of focus groups. Additionally, a total of 80 high students participated in the regional youth summit.
- *Oakland High School Youth Council Survey*, a student-led needs assessment of over half the Oakland High School students (n=1,018) to assess health needs and justify the need for a school-based health center.
- *Fremont Student, Parent Staff and Stakeholder Surveys, Interviews and Reflections:* A number of data collection activities were implemented in the Fremont area to assess student health needs and assist with health center program planning, including Student Surveys (n=119); Student Reflections (n=242); Parent Surveys (n=137); Staff Surveys (n=65); and a Force Field Analysis based on the results of interviews with key stakeholders including principals, counselors, school nurses and other key staff, as well as staff from the school district, the Family Resource Center, and the Office of Alameda County Supervisor Scott Haggerty.
- *Youth-led Research Projects in San Lorenzo, Berkeley and Alameda*, conducted in partnership with the school-based health centers at their schools, in which the youth researchers identified stress, depression, and suicide as important health issues facing their peers.

SECTION III - RECOMMENDATIONS:

Self-inflicted harm, such as suicide or the attempt to commit suicide, is an important mental health issue among adolescents in Alameda County. Each year an estimated 11 Alameda County youth ages 15-24 die from suicide and over 100 are hospitalized for attempting suicide. The suicide rate among youth is similar in Alameda County (5 per 100,000) and California as a whole (7 per 100,000)[2]. Alarmingly, in October/November 2007, there were three suicides in the Tri-Valley area within a four-week time span. These recent events underscore the need for immediate implementation of prevention strategies and early intervention efforts.

Underlying mental health concerns and the lack of social supports contribute to suicidal ideation in Alameda County youth. County-wide, 34% of 11th graders experienced substantial depression in the past year; they felt so sad and hopeless almost everyday for at least two weeks that they stopped doing some usual activities[3]. City specific data also demonstrates the prevalence of these issues. For example:

- Many youth in all Alameda County schools are dealing with suicidal ideation.
  - Youth researchers in Fremont, Berkeley, Oakland and San Lorenzo found that approximately 20-25% of their peers reported having considered suicide in the recent months. Students surveyed at Berkeley High who had considered suicide in the past two weeks were also more likely than their peers who did not report having these thoughts to show many more signs of depression, including having a hard time trusting people and feeling negatively about their grades, like they did not fit in at school, and that their lives were not always worth living.
  - The Oakland High needs assessment found that while the majority (77%) of females who had thought about ending their lives in the past year indicated that they had someone with whom to talk, 51% of males said they did not.
- Youth lack access to resources and information to seek help they need.
  - In Tri-Valley, many youth reported that they do not receive counseling to help deal with issues, such as stress and depression. Nearly half (44%) said that they only sometimes (15%) or never (29%) received counseling when they needed it to help deal with issues like stress, depression, or family problems.
  - The City of Fremont needs assessment found that 10% of Fremont High School students did not have an adult, other than their parent/guardian, who they could go to for help, and that 14% did not have a teacher that gave them the support they need to do well in school.

Based on the needs assessment findings and planning efforts in all of these schools, the youth researchers and councils proposed several recommendations to address the mental health needs of their peers that were echoed by staff, parents, and key stakeholders throughout the County. Almost all of these recommendations were specific to the school setting.

Schools must play a larger role in suicide prevention, however many simply do not have the capacity or the resources to address this issue and many educators and school officials do not have the skills to recognize the warning signs of suicide[4].

[2] Youth Health and Wellness in Alameda County; 2006.
[3] California Health Kids Survey; 2005.
[4] Goldrick, L. (2005). Youth Suicide Prevention: Strengthening State Policies and School-Based Strategies. NGA Center for Best Practices Issue Brief.

A July 2004 poll by the University of Pennsylvania Annenberg Public Policy Center found that only one-third of high school staff members believed that their schools had a "clearly defined and coordinated process for identifying students who may have a mental-health condition."[5] In addition, too few schools educate students about suicide. The CDC's 2000 School Health Policies and Programs Study found that less than half the states require suicide prevention to be taught in at least one school grade.[6]

The President's New Freedom Commission on Mental Health Report (2003) recommends that schools take more proactive steps to identify students who are grappling with mental health problems.[7] Based on this recommendation and that of the Alameda County youth researchers and councils, parents, school staff, and other stakeholders, the Alameda County SHSC proposes implementing a countywide school-based suicide prevention strategy. This strategy would complement the overall School-Based Strategy that was proposed to raise awareness of, identify and address the broad spectrum of mental health concerns among school-aged youth.

The overarching strategy for youth suicide prevention and early intervention should provide a variety of methods to improve early identification, early intervention and referral and support for youth at-risk of suicide and their families. Recommended prevention and early intervention best practices for the SHSC Suicide Prevention Plan include:

- **Youth**: Youth education and support groups, and individual counseling, coaching, and case management.
  - The SHSC School-Based Strategy proposal has proposed using **Teen Screen** as a method to identify youth at risk of suicide, which would also serve as an effective practice for the proposed suicide prevention strategy.
  - Another promising program is **Signs of Suicide (SOS**), which raises awareness of suicide and screens for depression and other risk factors associated with suicide in high schools.
- **Families:** In home and school family support groups, counseling, consultation, education, referral and case management.
  - **Parents and Teachers as Allies:** Assists families and school professionals to identify the key warning signs of early-onset mental health illnesses in youth and is intended to provide an educational tool for advancing mutual understand and communication between families and school professionals.
  - **Strengthening Families Program:** An evidence-based family skills training program found to reduce problem behaviors, delinquency, and substance abuse in youth and to improve social competencies and school performance. This program is also being proposed as a suggested best practice for the County's School-Based PEI strategy.
- **Schools:** Training and consultation for school staff to identify students at-risk for suicide and provide referrals.
  - **Lifelines:** Curriculum includes information and attitudes about suicide, help seeking, and school resources and discussion of warning signs of suicide. The program also includes school-based model policies and procedures for responding to at-risk youth, suicide attempts, and completions and presentations for educators and parents.

Combined, SHSC PEI recommendations are targeted to achieve the following outcomes:

- *Individuals and Families:*
  - Increased knowledge of social, emotional, and behavioral issues
  - Enhanced resilience and protective factors
  - Reduced (controllable) risk factors
  - Improved parenting knowledge and skills
  - Increased appropriate health seeking and social support
- *School Program and System Outcomes:*
  - Increase in number of individuals/families from underserved populations who receive PEI services
  - Increase in number of organizations with a formal process for identifying individuals/families with social, emotional, and behavioral issues
  - Increased access to evidence-based mental health services by children and their families
- *Long-Term Community Outcomes:*
  - Improved mental health status among underserved youth populations
  - Reduced suicide and suicide ideation among Alameda County youth

[5] Ibid.
[6] Centers for Disease Control and Prevention, Department of Health and Human Services. *School Health Policies and Programs Study 2000.*
[7] President's New Freedom Commission on Mental Health. (2003). *Final Report for the President's New Freedom Commission on Mental Health.*

EXPOSE

Deserae Borras, Terrance Johnson, Taelyr Woolridge, Rosa Rangel, Nisha Sembi

Berkeley High School Health Center
Student Research Team
2003-2004

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Berkeley High School Health Center

A note from the Clinic Director

The Berkeley High School Health Center is very excited about this year's Student Research Team's project. The students themselves picked the topic of interest - Depression on campus, created their survey instrument, designed their data collection plan and did the data entry and analysis. The Berkeley High School Health Center is leading this project in the belief that school connectedness and academic success play a critical role in reducing risky behaviors and promoting adolescent health. We believe that teens can and should participate in the decision-making process to develop health programs in Berkeley schools. This project crosscuts academics and health by allowing students to have an educational opportunity while promoting student health.

– Kimi Sakashita – Berkeley High School Health Center Director

Description of BHS School Based Health Center

Established in 1991, the Berkeley High School Health Center is a collaborative project between the City of Berkeley and the Berkeley Unified School District. The health center is staffed by the director, associate director, mental health coordinator, health education coordinator, youth coordinator, two physician assistants, two medical assistants, two administrative assistants, a registered nurse, two to four medical residents, five mental health interns, and four health education interns. The health center currently offers counseling and a weekly depression group. Clients are seen by appointment or on a drop in basis.

Who we are…

 Hi! I'm **Nisha Sembi** and I was one of the five people chosen to be part of the Berkeley High School Student Research Team. I wanted to participate in this program because during the process of thinking about what I wanted to do as a future career, the medical field crossed my mind. Since I didn't really have any experience in the medical field, I thought that this program would give me an opportunity to get an inside look.

 My name is **Rosa X. Rangel**. I'm a junior at Berkeley High School and I was one of the five students who chose to participate in the Student Research Team. I wanted to be engaged in this project because I wanted to gain knowledge in the field of medicine. I have always been interested in the medical field and I wanted to know if my interest of medicine could lead to a career in this field. It was enjoyable going through this project because I learned a lot of new skills including making surveys. I believe I am a unique person because I stand out. I love photography and I am easy to get along with. I am rather friendly and I joke around with everyone so it makes me have a good sense of humor and a great personality.

 My name is **Terrance Johnson** and I am a junior at Berkeley High School. My passion is in the field of medicine but most importantly it is with helping others feel better. I saw this project as an opportunity to address the problems that we face daily as teens. Besides participating in various health projects, I also love to dance Afro- Haitian at Berkeley High School.

 My name is **Deserae Borras**. I am currently a junior at Berkeley High School and a part of the Community Partnership Academy. I plan to attend a four-year college directly after high school and study in the medical field. I joined the Student Research Team because it was a way to help people with their problems that they might have been going through. Part of the reason I plan to study in medicine is because I enjoy helping others and I felt this could be a beginning of that. I am looking forward to a successful career ahead of me and to achieving all my goals in life.

 My name is **Taelyr Woolridge** and I am a sophomore at Berkeley High School and I was one of five people to be chosen to participate in the Student Research Team. I wanted to be a part of this project because I am interested in different aspects of the medical field. I saw this project as an opportunity to address the problems of my peers here at Berkeley High. Besides being a part of EXPOSE, I am apart of program at Children's Hospital at Oakland called FACES for the Future, and I am also in Youth Together. On top of being in these various projects, I like to laugh and tell jokes as well as have fun.

Introduction to the project

Our project began with meeting our team members for the first time and getting to know each other. Five students made up our team. We began meeting in October 2003 and we met once a week during lunch and sometimes after school for the entire year. We selected the team name EXPOSE because we wanted to expose information about important health issues for teens. We then began brainstorming a topic and a tool. We chose depression because we believe that it branches out to other issues that teenagers face (such as teen pregnancy, drug abuse, violence, sex, self esteem/image, etc.). The tool that we selected was a survey. After choosing this, we started drafting the questions that we would ask.

Our research question was " What causes depression among teens at Berkeley High School?" The major questions that we wanted to answer were: "How depressed are Berkeley High students?" and "How does depression affect the lives of Berkeley High students?" We knew from personal experience that almost every teen is touched by depression at some point in their lives so we thought that this was an important issue that affects everyone. During this project we learned a lot about what we needed to do a research project and we became aware of mental health issues that are affecting teenagers today.

Now that we have this information we hope to help our peers who are depressed or who show symptoms of depression and come up with a solution to make them better. Based on our data, we have made recommendations to the health center, the school, and the community about how to better support depression in young people. It was important that we did this research rather than adults because students might feel more comfortable giving their information to students of their generation than adults.

Methodology

This group of researchers was picked by sending in applications and being called back by the coordinator who was at the time Anisha. Anisha picked five students from Berkeley High: Taelyr Woolridge, a sophomore, Nisha Sembi a sophomore, Rosa Rangel, a junior, Deserae Boras, a junior, and Terrance Johnson, a junior. We had at least one to two meetings at lunch a week and at least one meeting for two hours after school.

We began by brainstorming health issues that we felt were important to Berkeley High School students. It took us a long time to decide our question because at first we all wanted to do something different. We considered STDs, pregnancy, drug use and living in a single parent home because all of these things can bring a lot of stress and unhappiness to someone's life. But then we realized that all of these topics were connected to depression in many ways. Some of them caused depression and some of them happened because of depression. Because of this, we decided to research the question: " What causes depression among teens at Berkeley High School?" We collected a lot of information concerning various things that cause or are a result of depression in BHS students.

We developed this survey by first brainstorming a lot of questions that related to our topic. When we were finished, we realized that we had too many questions and the survey was too long so we decided to eliminate questions. We kept the questions that gave us the direct answers that best answered our research question. We also worded the questions in a way so we could get clear answers instead of 'maybe' answers. After we created our survey, we sent our list of questions to UCSF to be reviewed by their Human Subjects Review Board. They evaluated them and gave us the o.k. to begin data collection. We realized that the survey was still really long and that there were still a number of questions that could be eliminated. Our final survey resulted in 28 questions including demographic questions.

We decided to go out into classrooms and conduct our survey because we thought it would be fun to interact with people we normally don't talk to and we also felt it would be more personal and interesting for the students to see their peers conducting a survey instead of some grown ups. We decided to try to conduct an equal amount of surveys to each grade 9th - 12th. We decided to do English classes for 10th - 12th and IES (Identity and Ethnic Studies) classes for 9th graders. We picked at least two to three teachers for as many periods as they had of that certain grade in their classroom. In the end, we collected 272 surveys (95 – 9th graders; 65 – 10th graders; 54 – 11th graders; and 53 – 12th graders).

Once we collected data, we took all the surveys and had a meeting to learn how to put surveys in to Survey Monkey (an on-line data analysis tool). After that meeting, we each took home the surveys we had collected and put the data into the computer. After all of the data was entered, we were able to see our results. We then analyzed this data and made conclusions and recommendations from what we had found. To do this, we used Survey Monkey to look at specific data sets. The most valuable data sets we compared looked at the students who had thought about death and suicide within the past 4 weeks versus those who had not thought about death or suicide. We were also able to look to see if there were any differences in responses among students in different grades or different ethnicities, but we didn't find any. Based on our

findings, we made recommendations for future research and for programs that could better address depression among teens.

We presented our findings to the mayor, the health center staff and to local mental health providers so that they could take action based on our data.

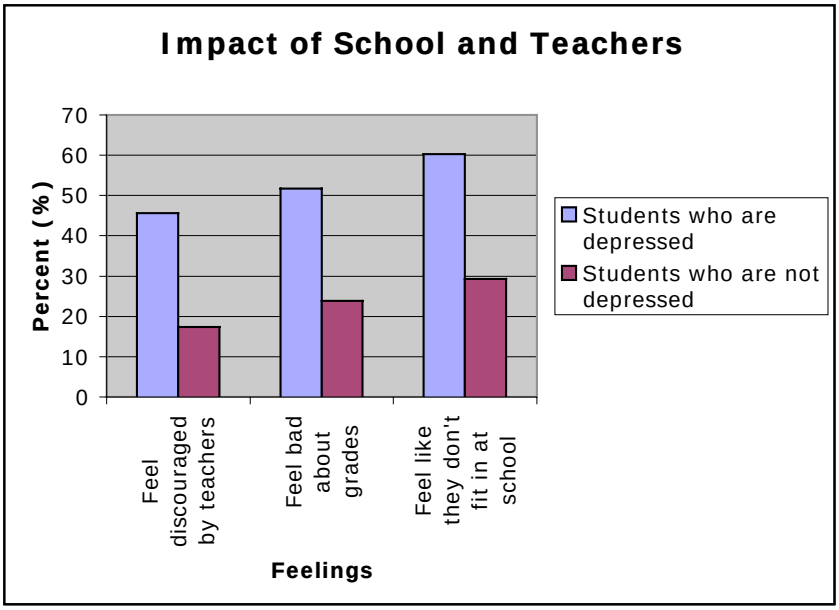
Data Analysis

Overall, we were initially disappointed by the results of our data because looking at the results we did not see major signs of depression among the sample even though we know that many students are stressed, bummed out and depressed. One of the questions that we asked was "Have you thought about death or suicide in the past two weeks?" When we looked at the data sets of who answered "yes" to this question versus who answered "no" we were able to see that the students who answered "yes" showed many more signs of depression. While the group who said that they had thought about suicide and depression in the past four weeks was only 22.4% of our sample, this comparison between those who considered suicide and those who didn't was an important part of our data analysis.

For this report, we will define the students who have had thoughts of death and suicide as depressed versus those who did not have thoughts of death and suicide.

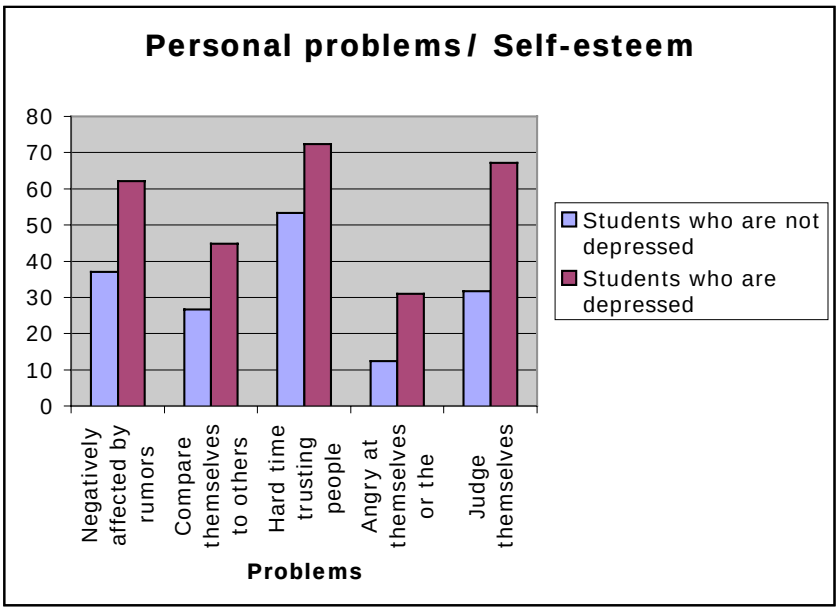
Finding #1: School and teachers impact student's feelings of depression and feelings of suicide.

- 17.4% of the students who are not depressed surveyed feel discouraged by their teachers versus 45.6% of the students who are depressed.
- 23.8% of students who are not depressed said they have always or often felt bad about their grades versus 51.7% of the students who are depressed.
- 29.3% of the students who are not depressed said that they always, often, or sometimes feel like they don't fit in at school compared to the 60.3% of the students who are depressed.



Finding #2: Students who said they have thought about death or suicide, showed signs that they have personal problems/ self-esteem issues.

- 62.1% of students who are depressed said that they have been negatively affected by rumors versus 37.1% of the students who are not depressed.
- 44.8% of students who are depressed said that they compare themselves to others versus 26.6% of the students who are not depressed.
- 72.4% of students who are depressed said that they have a hard time trusting people versus 53.3% of the students who are not depressed.
- 31.0% of students who are depressed said that they are always or often angry towards themselves or the world compared to 12.4% of the students who are not depressed.
- 67.2% of students who are depressed said that they judge themselves compared to 31.7% of the students who are not depressed.

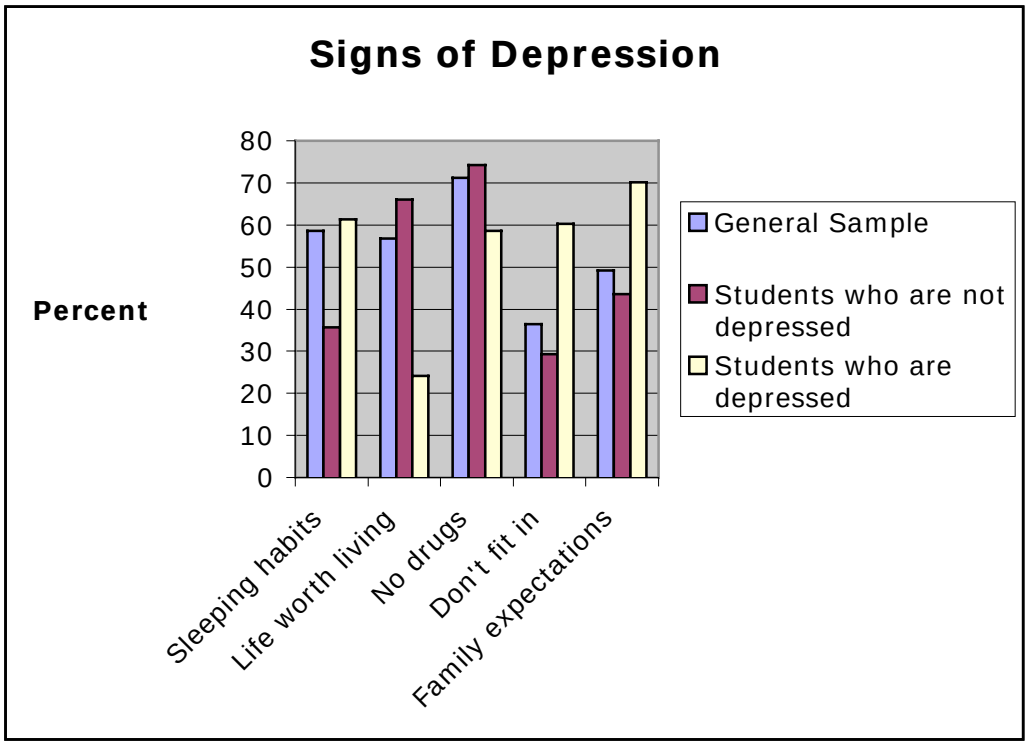


Finding #3: It's challenging to measure depression in teens except when they are suicidal. When you look at people who are thinking about death or suicide, you can see many more signs of depression.

- In the general sample, 58.6% of students said that they had no recent changes in their sleeping habits. In looking at depressed versus non-depressed students, 35.7% of students who are not depressed said that they have not had any changes in their sleeping habits versus 61.4% of depressed students.
- In the general sample, 56.8% of students said that they feel that their life is worth living all of the time. In looking at depressed versus non-depressed students, 66.0% of students who were not depressed said that they feel their life is worth living all the time where as only 24.1% of the students who are depressed said that they always feel their life is worth living all the time.
- In the general sample, 71.2% of students said that they never use drugs excessively to make themselves feel better. In looking at depressed versus non-depressed students 58.6% of depressed students said that they never use drugs excessively to make themselves feel better

while 74.3% of students who are not depressed said that they never use drugs excessively to make themselves feel better.

- In the general sample, 36.4% of students said that they sometimes, always or often feel like they don't fit in at school. When looking at the depressed versus non-depressed students, 60.3% of depressed students said that they sometimes, always or often feel like they don't fit in at school compared to 29.3% of students who are not depressed.
- In the general sample, 49.2% of students said that they feel that their family's expectations affect the way they feel about themselves. When looking at the depressed versus non-depressed students, 70.2% of the depressed students said that they are affected by their family's expectations while only 43.5% of the students who are not depressed are affected by family expectations.



In conclusion, there has been a pattern that has shown that there is a drastic difference in numbers (percentages) between the general population of those surveyed and the specific students who show serious signs of depression.

Limitations

While we did a lot to make sure that we got the best possible data, we know that there are some limitations to the data collected.

- One thing that could have been better was the way we performed the survey inside the classrooms. We feel that the environment in some of the classrooms was inappropriate for students to feel comfortable thinking about depression. Because some of the students were not cooperating during the survey, other students, who were taking it seriously may have felt uncomfortable providing honest answers.

- The majority of the classes in our sample were part of C.P.A. which has more minority students and that may have caused the imbalance of ethnicities/races that took the survey.

- Another point we could have paid closer attention to was getting equal number of students in each grade that would take the surveys.

- We also believe that asking more direct questions could have resulted in better answers that could have supported us in making better recommendations on what to do to address depression among BHS students. (Ex. Questions whether people are bummed out and why?; What kind of support do you need when you are bummed out?)

- One important limitation that we noticed was when people contradicted themselves in their answers. This makes us believe that many students who took the survey were not being completely honest. This may have been due to the fact that people were uncomfortable talking about mental health or it could be that people didn't want to come across as depressed.

- Because we know our own experiences and we see other people who are bummed out we had expectations that we would see more signs of depression among people who took the survey. Because there were not a lot of signs of depression in our data we were initially disappointed with the results. We feel that it is important to think more about how to measure the signs of depression in youth.

Recommendations and Next Steps

Based on the results of our project, we have the following recommendations:

- Because depression is so hard to detect among teens, and many people don't want to be classified as depressed, counseling for depression should be integrated into all services for BHS youth. All teachers, staff, and health center staff should be trained to provide support to depressed teens.

- There should be more education about depression and mental health at Berkeley High School. Because depression can affect anyone at anytime, it is important that all students take one or more classes that talk about mental health. It should be integrated into required courses for 9th graders like Identity and Ethnic Studies, and then integrated into other classes for upper classmen.

- Because people primarily turn to their friends for support, it is important that we train students to support each other. This training should be offered to the general student population and peer educators specifically trained in depression should conduct the training.

- At the beginning of this project, none of us were aware of the depression support group on campus and we have not seen any fliers about it. We suspect that many other students also are unaware of the available services and we feel that the health center should do better advertising for the mental health services already offered at BHS.

- Because there is a lot of stigma about depression both in school and in the community, there should be a Community Education Campaign about teen depression. This should include conducting more research to find out what the community can do about teen depression.

- Teachers need to have an orientation on teen depression and they need to be made aware of the impact they and their expectations can have on teens. Because school contributes greatly to teen depression, it is important that teachers are well educated.

- We recommend that the Student Research Team next year continue looking at this topic and research more on solutions and responses that can help solve depression.

- Due to our results showing the fact that students who are thinking about death and suicide have many more signs of depression, we think it is important to do additional research to determine what causes the shift from someone feeling bummed out to someone thinking about death.

What we learned…

One of the most valuable parts of this project was the data analysis. Although we were first disappointed by the results, the analysis helped us really look at the students who were considering death and suicide. By entering the data into Survey Monkey, we were able to go through it all and see the answers that the students were giving. Sometimes the information was really surprising.

This project was also a great opportunity to interact with students in other grades. During data collection, we were able to talk with new students and get their ideas about depression.

Presenting our work on this project at a conference also was great because it helped us to keep going with the project. Because other people were interested in our results and our work, it kept us going.

Thank you's

We would all like to thank Mr. Skeels, Ms. Bell, Ms. Z, Mrs. Trahan, Anisha Wharton, Ahna Ballonoff, Samira Soleimanpour, Kimi Sakashita and all the students who participated in taking the survey.

This project and publication were made possible by funding from the Centers for Disease Control and Prevention (Cooperative Agreement Number R06/CCR921786) and through the support of University of California, San Francisco, Youth in Focus, and the Alameda County School-Based Health Center Coalition. Its contents are solely the responsibility of the authors and do not necessarily represent the official views of CDC.

Appendix A – Our Survey

EXPOSE

Student Research Team Berkeley High School

This survey was created for teens by teens. Five of your peers participated in creating this survey. We developed this survey because we feel that mental health is really important. Your information will contribute to better Mental Health services here at Berkeley High.

You do not need to put your name on this survey. All of your answers will be kept confidential.

Directions: Please check the most appropriate response to each statement.

Section 1: Demographics

1. Gender:
   ☐ Male ☐ Female ☐ Other

2. Grade:
   ☐ 9th ☐ 10th ☐ 11th ☐ 12th

3. Age:
   ☐ 13 ☐ 14 ☐ 15 ☐ 16 ☐ 17 ☐ 18 ☐ 19

4. Race:
   ☐ African/ African American ☐ Asian/ Pacific Islander ☐ Arab/ Middle Eastern
   ☐ Bi-racial/ multi-racial _____ ☐ Chicano/a/ Latino/a/ Hispanic ☐ White/ European American
   ☐ Other _____

5. Do you live in a single parent home?
   ☐ Yes ☐ No

Section 2: How are you feeling?

6. How often do you feel your life is worth living?
   ☐ All the time ☐ Often ☐ Sometimes ☐ Rarely ☐ Never

7. How often do you find yourself losing interest in your hobbies?
   ☐ All the time ☐ Often ☐ Sometimes ☐ Rarely ☐ Never

8. How often do you find yourself easily irritated/ bothered by other people and things?
   ☐ All the time ☐ Often ☐ Sometimes ☐ Rarely ☐ Never

9. Do you find that you judge yourself?
   ☐ Yes ☐ No ☐ Sometimes

10. How often in the past 4 weeks has your appetite been either less than usual or greater than usual?
    ☐ Not at all ☐ 1-3 days a week ☐ Most days of the week ☐ Nearly every day for at least 2 weeks

11. Have you thought about death or suicide in the past 4 weeks?
    ☐ Yes ☐ No

12. How often do you use drugs excessively to make yourself feel better?
    ☐ Always ☐ Often ☐ Sometimes ☐ Never (I never use drugs)

13. Has there recently been any change in your sleeping habits?
    ☐ I sleep more than usual ☐ I sleep as much as usual ☐ I sleep less than usual

Section 3: Relationships

14. Who do you feel like you can trust or talk to? (CHECK ALL THAT APPLY)

☐ Parent/ family member ☐ Counselor ☐ Teacher ☐ Friend ☐ Other _____ ☐ No one

15. Do you have a hard time trusting people?

☐ Yes ☐ No

16. In the past year, have you been in a serious relationship (boyfriend/ girlfriend)?

☐ Yes (please go on to the next question) ☐ No (please go on to question 19)

17. Do you feel your boyfriend(s)/ girlfriend(s) have ever expected things of you that you're not ready for?

☐ Yes ☐ No

18. Do you find that you try to distance yourself from your boyfriend/ girlfriend or friends a lot?

☐ Yes ☐ No

Section 4: School

19. If you had a choice would you still be attending school?

☐ Yes ☐ No ☐ Maybe

20. Do you ever feel discouraged by your teachers?

☐ Yes ☐ No ☐ Sometimes

21. How often do you feel like you don't fit in at school?

☐ Always ☐ Often ☐ Sometimes ☐ Rarely ☐ Never

22. Have you ever been negatively affected by rumors?

☐ Yes ☐ No

23. How often do you feel bad about your grades?

☐ Always ☐ Often ☐ Sometimes ☐ Rarely ☐ Never

Section 5: Self-image/ Self Esteem

24 . Do you compare yourself to others?

☐ Yes ☐ No ☐ Sometimes

25. How often do you feel angry at yourself or at the world?

☐ Always ☐ Often ☐ Sometimes ☐ Rarely ☐ Never

26. Do you find yourself smiling to hide your true feelings?

☐ Yes ☐ No ☐ Sometimes

27. Do your family's expectations of you affect the way you feel about yourself?

☐ Yes ☐ No

28. How often do you feel a lot of peer pressure around you that makes you feel unhappy with yourself?

☐ Always ☐ Often ☐ Sometimes ☐ Rarely ☐ Never

Thank you for taking time to participate in this survey.

Appendix B – Our Data

Total Number of Surveys Completed = 272

Section 1: Demographics

1. Gender:
   Male 125 (46.8%) **Female 137 (51.3%)** Other 5 (1.9%)

2. Grade:
   9th 95 (35.6%) 10th 65 (24.3%) 11th 54 (20.2%) 12th 53 (19.9%)

3. Age:
   13 – 5 (1.9%) 14 – 54 (20.5%) 15 – 59 (22.3%) **16 – 63 (23.9%)** 17 – 46 (17.4%) 18 – 35 (13.3%) 19 – 2 (0.8%)

4. Race:
   African/ African American 102 (39.1%) Asian/ Pacific Islander 16 (6.1%)
   Arab/ Middle Eastern 27 (10.3%) Bi-racial/ multi-racial 27 (10.3%)
   Chicano/a/ Latino/a/ Hispanic 40 (15.3%) White/ European American 55 (21.1%) Other 17 (6.5%)

5. Do you live in a single parent home?
   Yes 119 (45.5&) **No 143 (54.6%)**

Section 2: How are you feeling?

6. How often do you feel your life is worth living?
   All the time 150 (56.8%) Often 67 (25.4%) Sometimes88 (33%) Rarely 95 (35.6) Never 33 (12.4%)

7. How often do you find yourself losing interest in your hobbies?
   All the time 7 (2.6%) Often 44 (16.5%) Sometimes 88 (33%) **Rarely 95 (35.6%)** Never 33 (12.4%)

8. How often do you find yourself easily irritated/ bothered by other people and things?
   All the time 38 (14.4%) Often 42 (16%) **Sometimes 122 (46.6%)** Rarely 54 (20.5%) Never 7 (2.7%)

9. Do you find that you judge yourself?
   Yes 103 (39.2%) No 49 (18.6%) **Sometimes 111 (42.4%)**

10. How often in the past 4 weeks has your appetite been either less than usual or greater than usual?
    Not at all 139 (52.7%) 1-3 days a week 73 (27.7%) Most days of the week 31 (11.7%)
    Nearly every day for at least 2 weeks 21 (8%)

11. Have you thought about death or suicide in the past 4 weeks?
    Yes 58 (22.1%) **No 205 (77.9%)**

12. How often do you use drugs excessively to make yourself feel better?
    Always14 (5.3%) Often 14 (5.3%) Sometimes 48 (18.2%) **Never (I never use drugs) 188 (71.2%)**

13. Has there recently been any change in your sleeping habits?
    I sleep more than usual 40 (15.3%) **I sleep as much as usual 153 (58.6%)** I sleep less than usual 68 (261%)

Section 3: Relationships

14. Who do you feel like you can trust or talk to? (CHECK ALL THAT APPLY)
    Parent/ family member152 (56.9%) Counselor 40 (15%) Teacher 52 (19.5%)
    Friend 191 (71.5%) Other 34 (12.7%) No one 32 (12%)

15. Do you have a hard time trusting people?
    Yes 137 (52.5%) No 124 (47.5%)

16 In the past year, have you been in a serious relationship (boyfriend/ girlfriend)?
   Yes (please go on to the next question) 134 (50.6%) No (please go on to question 19) 131 (49.4%)

17. Do you feel your boyfriend(s)/ girlfriend(s) have ever expected things of you that you're not ready for?
Yes 40 (27.8%) **No 104 (72.2%)**

18. Do you find that you try to distance yourself from your boyfriend/ girlfriend or friends a lot?
Yes 40 (29.7%) **No 102 (70.3%)**

Section 4: School

19. If you had a choice would you still be attending school?
Yes 170 (64.2%) No 25 (9.4%) Maybe 70 (26.4%)

20. Do you ever feel discouraged by your teachers?
Yes 62 (23.7%) **No 118 (45%)** Sometimes 82 (31.3%)

21 How often do you feel like you don't fit in at school?
Always 14 (5.3%) Often 25 (9.5%) Sometimes 57 (31.6%) Rarely 80 (30.3$) **Never 88 (33.3%)**

22 Have you ever been negatively affected by rumors?
Yes 113 (42.8%) **No 151 (57.2%)**

23 How often do you feel bad about your grades?
Always 31 (11.7%) Often 47 (17.8%) **Sometimes 102 (38.6%)** Rarely 60 (22.7%) Never 24 (9.1%)

Section 5: Self-image/ Self Esteem

24. Do you compare yourself to others?
Yes 82 (30.4%) No 92 (34.1%) **Sometimes 96 (35.6%)**

25. How often do you feel angry at yourself or at the world?
Always 13 (4.8%) Often 33 (12.3%) Sometimes 75 (27.9%) **Rarely 83 (30.9%)** Never 65 (24.2%)

26. Do you find yourself smiling to hide your true feelings?
Yes 66 (24.5%) **No 122 (45.4%)** Sometimes 81 (30.1%)

27. Do your family's expectations of you affect the way you feel about yourself?
Yes 131 (49.2%) **No 135 (50.8%)**

28. How often do you feel a lot of peer pressure around you that makes you feel unhappy with yourself?
Always 15 (5.6%) Often 16 (6%0 Sometimes 56 (21%) Rarely 97 (36.3%) **Never 83 (31.1%)**

DIVAS

Discovering Individual Views About Stress

Encinal High School
Student Research Team

"How Does Stress Affect Students At Encinal High School/ Island High School and How Do They Keep It At A Safe Level?"

2005

TABLE OF CONTENTS

BIOGRAPHIES

Emily Chow

Hi, my name is Emily Chow. I'm 14 years old and I'm a freshman at Encinal High School. My hobbies include arts and crafts and eating! I wanted to be a part of the EHS Student Research Team because I thought it would be a lot of fun to meet new friends and to work as a team – and it is! I also wanted to be a part of the team because I thought it was important to be more involved in my school and I felt I could make a difference. My time with the SRT has been AWESOME! I love going to the meetings because they are always filled with fun! I love my team members and Ariana, our coordinator. I wish I could do it all over again!

Emily Fuentes

Hey, I'm Emily! I am 17 years old and a junior at Encinal. When I heard about the Student Research Team I was so eager to apply and to get a chance to work in another youth group. I have been involved in a myriad of teen groups and enjoy it all so much. I wanted to expand my leadership and communications skills. The Student Research Team has opened my eyes to a whole world of opportunities for the future, like working in the health and research field. Besides that, just being able to meet new people in the group was worth it all!! I love to play games and this year with the team was loads of fun.

Freshta Kohgadai

Salaam (Hi). My name is Freshta Kohgadai, I'm 17 and I'm in the 11th grade. The thing that's important to me is the satisfaction in knowing I have friends and I am loved - the fact that I have family and friends I can count on and having people to trust. My religion and culture are really important to me. I participated in this project because I wanted to have an opportunity to help people. Knowing that I can do something to help not just my friends, but everyone who attends school at Encinal and Island makes me feel like I have accomplished something important in my life.

Muzit Tzehaye

Hi I'm Muzit Tzehaye. I am 16 years old and I go to Encinal High School. I was born in Eritrea (East Africa). I came to the United States when I was 8 years old. I'm an only child. I am a very fun and interesting person. I joined the SRT because I wanted to meet new people and also learn more about some of the health issues that teens such as myself go through. This program (SRT) is so much fun and you can learn a lot from it, which I have. I have learned to work and cooperate with other people. My group was so wonderful and caring that we didn't consider it as work, but a fun after school activity. I had a blast in this program and I would do it again any time.

Haticia Peters

Haticia Peters is a senior at Island High School and acted as the team's connection to Island students and teachers. She was excited to work with the Student Research Team and enjoyed getting to know the other team members.

COORDINATOR STATEMENT

Over the past year, I have had the opportunity to work closely with an incredible group of students – the Encinal High School Student Research Team (SRT). The SRT project arose out of the comprehensive evaluation of School Based Health Centers that is being conducted by the University of California, San Francisco. A partnership between the Alameda County Coalition of School Based Health Centers, UCSF, and the Centers for Disease Control and Prevention allowed for the development of this on-site youth-led research and evaluation project. The incredible young people that you will hear from throughout this report spent this school year working on their own health-related research project with the intention of developing a more nuanced understanding of a health issue that faces their peers. Their goal was to make recommendations based on their findings that would help Tri-High improve our services and better meet the needs of our diverse student body.

Youth are often the subjects of research, but too rarely are they behind the projects. Too often programs are designed to impact the lives of youth, but the time isn't taken to involve youth in the process – to ask them what they want or need. The greatest thing about the SRT project is that it is *youth-led*. This means that these young people were truly the driving force behind the work you will see here – they identified issues that were important to the young people on their campuses; they developed their own research tools; they gathered and analyzed their own data; they made the decisions. This project is about hearing youth voices. The challenge for us, as adults, is that we have to sit back and really listen. This kind of partnership with youth is what will allow Tri-High to make meaningful and lasting changes.

The team whose vision and dedication are represented in this report are the product of a rigorous selection process that occurred at the beginning of the year. Over sixty students from this school applied to be Researchers, most were interviewed, and these five were selected. This project has been a huge success largely because of the partners who have supported us along the way. Youth In Focus, an organization that trains young people to engage in this kind of action research, has been an amazing resource; UCSF staff has taken care of our logistics; and Tri-High staff has welcomed the Student Researchers and shared in their excitement. We have gone through a lot together throughout the year and we have learned a lot, not only about research, but also about each other.

I have so enjoyed having the opportunity to work with these young people, as this has been an incredibly rewarding process to be a part of. I have been continually amazed by the energy, insight, honesty, commitment, teamwork, and humor that is demonstrated by each of these students and I feel so lucky that they have shared their strengths with me and with each other.

To the team – surely knowing and working with each one of you has made me a better youth ally, a better facilitator, a better person. Thank you for it all.

Ariana Bennett

Student Research Coordinator

ABOUT TRI-HIGH HEALTH CENTER AT ENCINAL HIGH SCHOOL

Tri-High's mission is to provide "high-quality health care services" to teens. It improves students' personal lives so they can do better in school.

Tri-High has medical services such as sports physicals, vision and hearing screenings, immunizations, etc. It has health education on human sexuality, pregnancy prevention, substance abuse prevention, and youth empowerment. It also has counseling/therapy where you can talk about anything, ranging from eating disorders or depression to stress management.

The Encinal Tri-High Health Center serves a very diverse school. Encinal High School has students from all different nationalities that are united into one school. Encinal students are very active and spirited and care about what goes on in the community. So it was no coincidence that the Student Research Team reflected the school's diversity.

Our team name is DIVAS, which stands for "Discovering Individual Views About Stress." We are all girls, all powerful, and all eager to make a change in our community. The purpose of the SRT is to research an issue that teens at our school face and to try to find a solution to better their lives.

INTRODUCTION TO THE PROJECT

Our research question was: "How does stress affect students at Encinal and Island High Schools and how do they keep it at a safe level?" We believe that stress is one of the main factors that leads up to bigger health issues. It affects many students and people, and it also affects us because everyone gets stressed once in a while. Stress was related to all the other health topics that interested us, so we figured why not attack the root of the problem.

The major questions we wanted to answer were:

- What makes students stressed?
- What are the effects of stress?
- How do they deal with it?
- What do they do when they are stressed?
- How do demographics and economics affect students' stress levels?

It was important that *we* did this research rather than adults because we understand teens better, being teens ourselves and going through the same life pressures as them.

We plan for students to use our information to be able to handle their stress. It will help teens by showing them that they are not alone, teaching them causes and consequences, if they didn't know before hand, and last by showing everyone that stress is a very important issue to address.

METHODOLOGY

The students that participated in the Research Team were 6 out of approximately 60 other students. The Student Researchers were selected by Ariana Bennett, the coordinator, based on an application and an interview in which we were asked questions on why we wanted the position, what we could contribute, and how we would react to various situations. Originally we had 6 members, however one member decided to leave, so we continued on with only 5 members. We met once a week unless we needed more time to work.

Once started, we decided on a question to research. We chose the question, "How does stress affect students at Encinal and Island High Schools and how do they keep it at a safe level?" because we wanted to find out the causes and effects of stress and how to solve it.

To get the information, we chose to use a survey because it is confidential and can be mass distributed. Also, it is quick and easy for students, too. We thought it would be the best way to make the most of our time. We felt it was important to include all of our school and its diversity, so our sample was a well-balanced group of students in grades 9-12. We developed our survey by compiling questions we thought were important to know the answers to. We also thought it was important to include different types of questions including: ranking, rating, and multiple choice. We decided to distribute surveys to English classes because they include students of many different backgrounds and stress levels. We collected our data from various English classes at Encinal and Island High Schools.

Once the surveys were distributed we collected a total of 260 surveys. We entered the data into a program called Survey Monkey, where we were able to see all of the data together. One of the cool things about Survey Monkey is that we were able to filter out specific data. For example, we could separate the data from Encinal High School from Island High School, girls from boys, as well as the different ethnicities.

Once the data results were in front of us and filtered, we dove into the rigorous task of analyzing the data and locating findings by searching through our information and looking at anything that stood out or surprised us. For example, one of our findings is as follows: the question was, "Who would you go to talk about stress and to get help?" We discovered that many students were not likely to talk to Tri-High counselors about stress and to receive help. This in interesting since Tri-High is a great available resource for students and now, with this information, Tri-High can better advertise their resources and change the opinions of students.

DATA ANALYSIS

We learned a great amount about stress and its effects on students with our data. With the results, we concluded on 9 findings with supporting data.

FINDING: School is so stressful and time consuming that students are not aware of anything else that causes stress.

SUPPORTING DATA:

- 52% of students say that their first priority is school.
- 64.1% of students say they *are* aware of the effects of stress on their lives, however, 42% of students say they *are not* aware of stress outside of school.
- 60% agree or strongly agree that their grades begin to suffer when they are stressed.
- 47% of students surveyed say that schoolwork causes stress.

FINDING: Stress would be reduced if one organized their time! And this helps keep grades up!

SUPPORTING DATA:

- Most students do not organize their time, but of those that do, the majority say it helps to control stress.
- The majority of students (68.9%) do homework directly after school.
- 43.5% of people's grades suffer when stressed (and organization would help!)

FINDING: Before this survey we expected to see a reasonable amount of students agree that ethnicity and economic status cause stress. With our analysis of seeing each ethnicity separately, we found that the majority of students from each group disagree to strongly disagree with those statements.

SUPPORTING DATA:

Race/Ethnicity	***"Race and ethnicity cause stress"***		***"Economic status causes stress"***	
	Disagree (%)	*Strongly Disagree (%)*	*Disagree (%)*	*Strongly Disagree (%)*
Middle Eastern	11.1	44.4	11.1	55.6
Hawaiian / Pacific Islander	55.6	31.1	45.5	34.1
White	32.9	42.9	40	40
African/ African American	30.5	50.8	36.2	50
Latino	15.4	66.7	35.1	43.2
Asian	39.7	42.9	48.4	32.3
Native American	22.2	33.3	44.4	44.4

FINDING: With our data, we see that girls generally put more effort into schoolwork than boys. Therefore, their stress is more school-related.

SUPPORTING DATA:

- 53% of girls organize their time, while 60% of boys do not.
- 77% of girls do homework right after school, while most boys relax (66%).
- 57% of girls (76) rate school as their top stressor, compared to 34% of boys (#36). In addition, 48% of girls (65) rate future goals as their top stressor, and 38% of boys (40) rate school as their *second* highest stressor.

FINDING: Teens talk about their problems or hang out with friends to relieve stress.

SUPPORTING DATA:

- 30.8% of students responded that they talk to people about it when they are stressed.
- 46.5% of students say that hanging out with friends helps them relax the most.
- 52% of students ranked friends as the #1 people they would talk to and ask for help.

FINDING: Students are most likely to go to their friends in order to talk about stress and get help, whereas students are least likely to go to a Tri-High counselor.

SUPPORTING DATA:

- 52% of students are most likely to go to friends for help with stress.
- 45% of students say they are least likely to go to a Tri-High counselor for help
- Only 4% of students say they were most likely to go to a Tri-High counselor for help

FINDING: Most teens don't realize the effects of stress on their lives and even if they do, the majority do not deal with it, but just continue on with their lives.

SUPPORTING DATA:

- 35.9% of students say they are *not* aware of the effects of stress on their life.
- 48.4% say that when they are stressed they just continue on with their lives.
- 25% of students do not talk to anyone or ask for help when they are stressed.

FINDING: Rest and relaxation resolve stress, however people don't have time for these when they are stressed.

SUPPORTING DATA:

- 63% of students say they don't have time to relax in a school day.
- 54% of students sleep less when they are stressed.

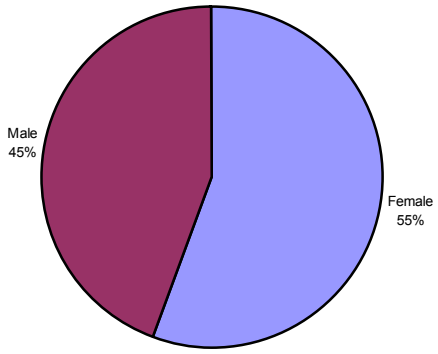
FINDING: When students are stressed their health begins to suffer and continues to suffer (because they don't try to handle the stress, they just move on with it).

SUPPORTING DATA:

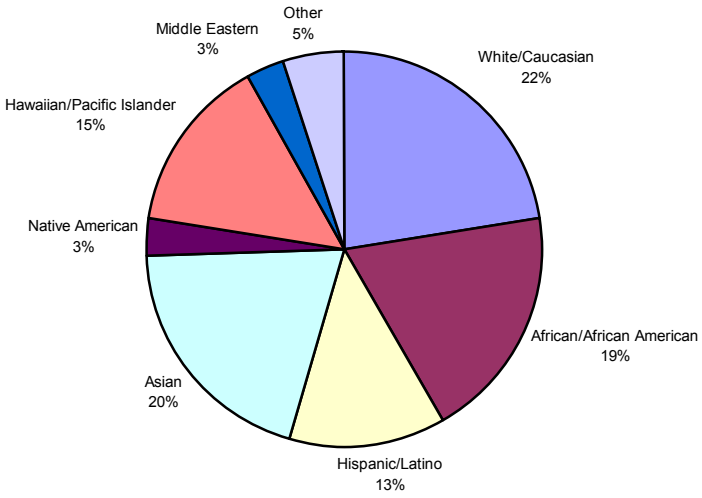
- When stressed, 4% of students use drugs/alcohol; 24% ignore responsibilities; 18% treat friends/family badly; 12% neglect their health; 68% feel irritated.
- 48% of students continue on with their lives when they are stressed and don't try to control it. Therefore, they continue on with these unhealthy habits, causing more future problems.

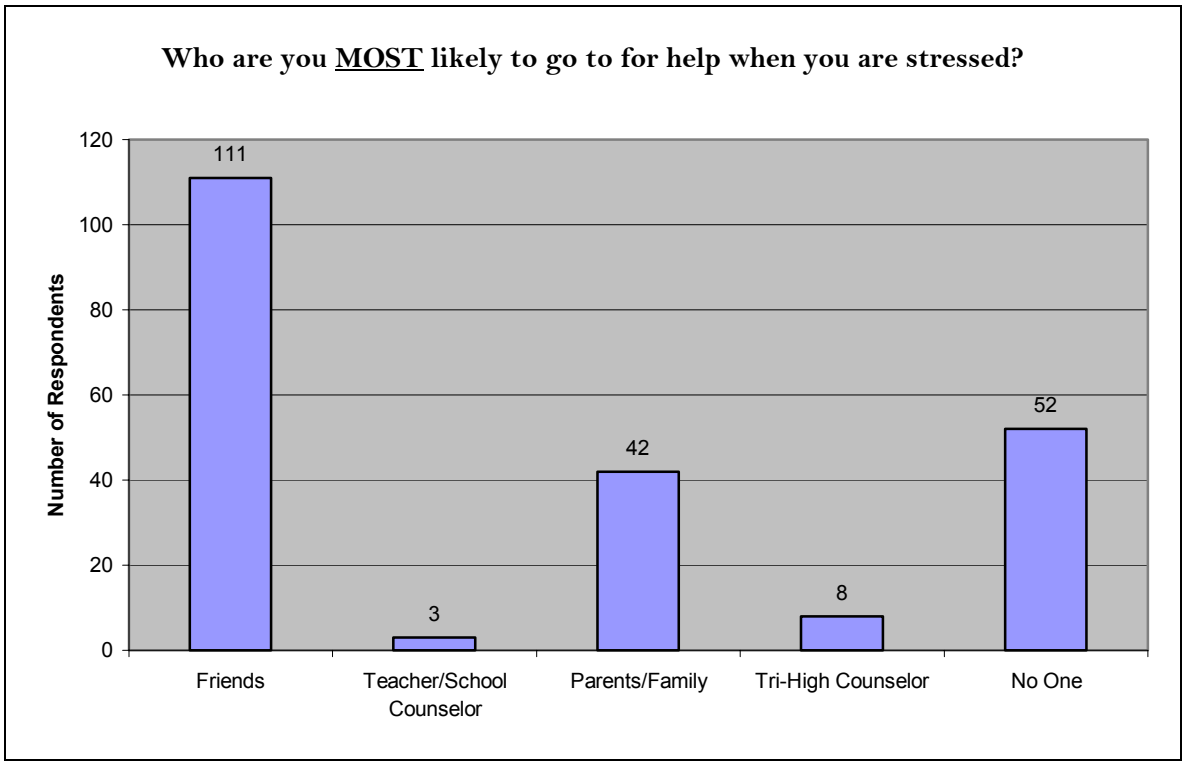
CHARTS AND GRAPHS

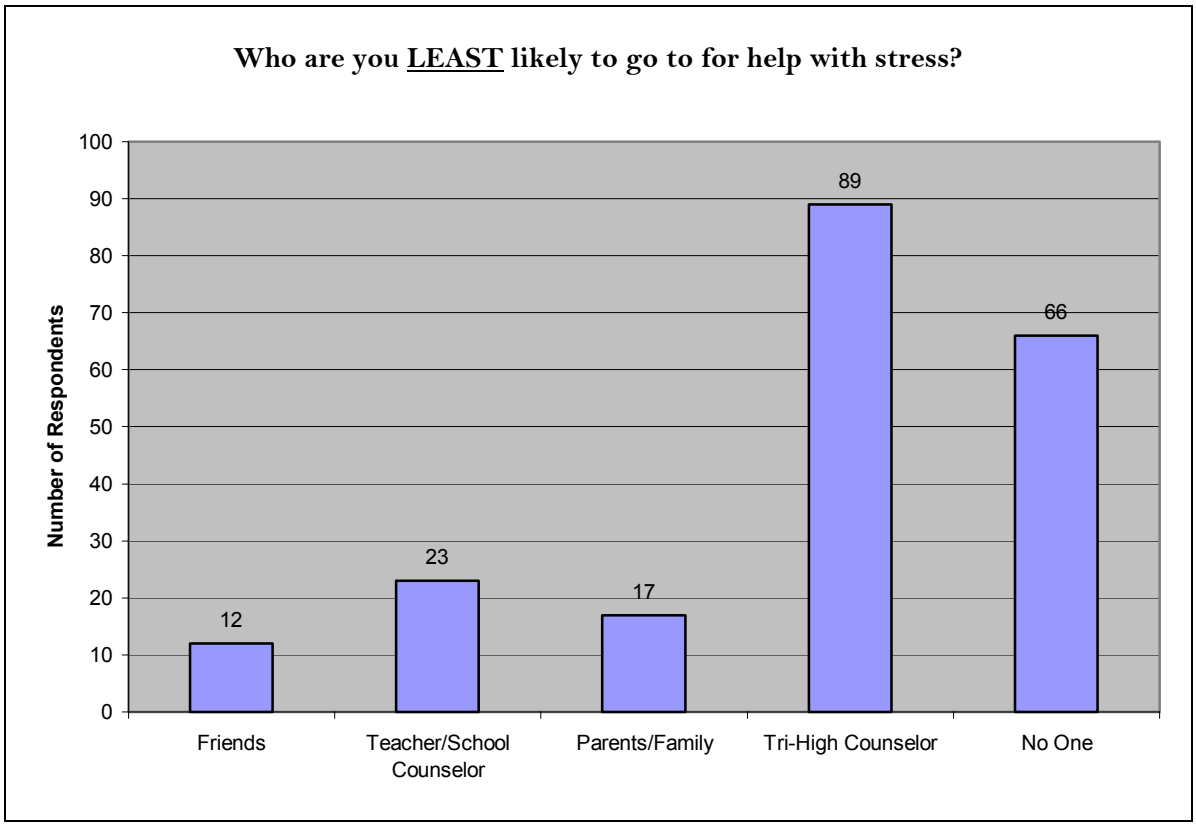
Gender Distribution of Students Surveyed

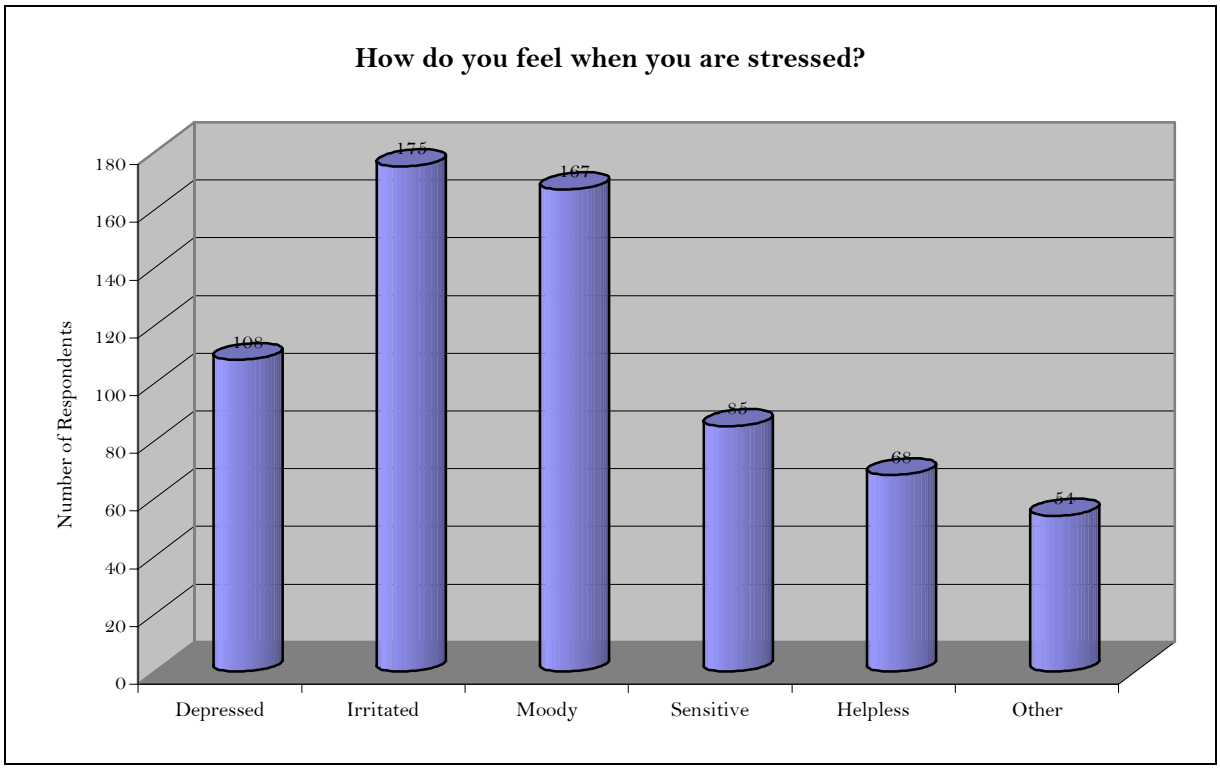


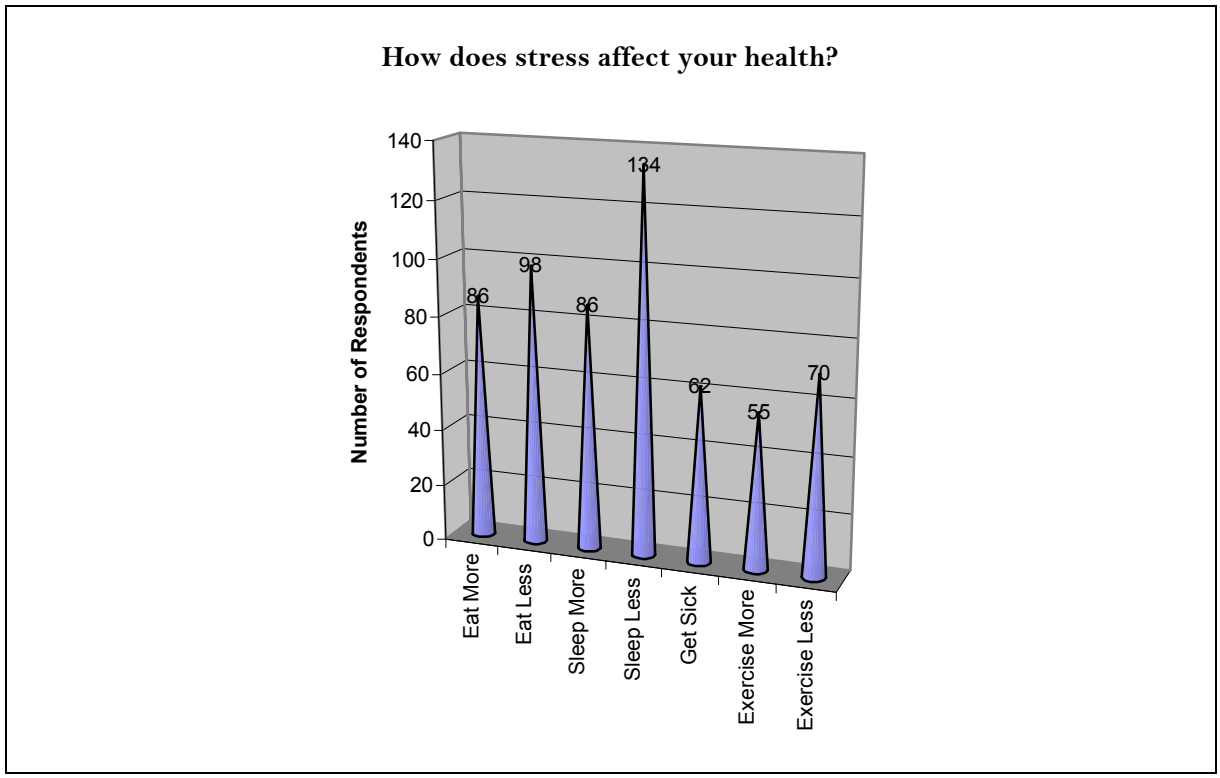
Race/Ethnicitiy of Students Surveyed




Who are you MOST likely to go to for help when you are stressed?
Number of Respondents
120
100
80
60
40
20
0
111
3
42
8
52
Friends
Teacher/School Counselor
Parents/Family
Tri-High Counselor
No One


Who are you LEAST likely to go to for help with stress?
Number of Respondents
100
90
80
70
60
50
40
30
20
10
0
12
23
17
89
66
Friends
Teacher/School Counselor
Parents/Family
Tri-High Counselor
No One


How do you feel when you are stressed?
Number of Respondents
0
20
40
60
80
100
120
140
160
180
108
175
167
95
68
54
Depressed
Irritated
Moody
Sensitive
Helpless
Other


How does stress affect your health?
Number of Respondents
0
20
40
60
80
100
120
140
86
98
86
134
62
55
70
Eat More
Eat Less
Sleep More
Sleep Less
Get Sick
Exercise More
Exercise Less

LIMITATIONS AND LESSONS LEARNED

After analyzing and reflecting on our project, we found some things that we could have done better. For example, we thought of questions we wished we had asked and other planning strategies we could have done to make the project run more smoothly. We came up with some project limitations and lessons learned:

1. Before developing the survey, we should have made a list of what we hoped to learn so that when we were developing questions we could make sure to cover everything.
2. Next time, we would come up with hypotheses for our questions and the results we expected to get so that our analysis would be stronger. This would help give us a focus when coming up with findings.
3. Before doing the survey, it would be good to ask other students what they want to learn about stress and then incorporate that.
4. It would be helpful to find out what kinds of de-stressing services students would actually use, to help with our recommendations. This could also be done as a follow-up to the research we already did.
5. Next time, we would want to have clearer communication to make sure we get the sample we need (this time we ended up with more 9th graders and fewer 11th graders than we wanted).

We learned so much during this year's project; some of the most important lessons about researching are as follows:

1. Communication and cooperation are the keys to success. We learned about teamwork and how to go ahead with our work even if some people don't come to meetings.
2. Be specific in your demands of people, including your teammates, teacher partners, and on surveys for students.
3. Set a timeline and work on time management so that everything gets done and you don't have to worry.
4. There are different ways to ask questions!
5. We had to be careful not to make assumptions in our data analysis because that can lead to false information.
6. Before we joined the SRT, we thought that we would be doing research on the internet. This research was real, active, and hands-on...we learned action research!

RECOMMENDATIONS AND NEXT STEPS

After analyzing and coming up with findings from our data we concluded on some recommendations for Tri-High and Encinal. We learned that not many students use the Tri-High services, not all students understand stress and its effects, and that stress can be controlled in a few easy ways. The following are our recommendations:

1. Create a brochure to inform students/teens about stress, including how to detect stress, the effects of stress, and how to control stress in a healthy way.
2. Have better advertisements for the Tri-High counselors because the majority of Encinal students don't think they would go to Tri-High for help with stress.
3. Have peer-counseling sessions available where students can talk about what is causing them stress and receive advice and help.
4. Offer time management and organization skills sessions to give advice to students on how to reduce stress by organizing and managing time. Teachers could offer one class period or one after school session on organizations to all students.
5. Offer one-on-one sessions with college graduates/successful people to help students plan their future and goals.
6. Have a spot where teenagers can hang out and spend time together in a safe, healthy environment, like an after school "chill grill."
7. Create a checklist or other form to help students through the different times of stress (for planning for a test, finals, or other things). It would be great to put this in the school agenda.
8. Encinal should offer classes and after school programs in relaxation practices like yoga and Pilates.

With such interesting findings and recommendations, we cannot just stop with this final report. Here are some next steps that we see as a result of this project as well as a few recommendations for future research:

1. We will present our data to Tri-High/Encinal counselors, teachers, and students so that we can make changes.
2. We will create the brochure on stress that is part of our recommendations and make it available to Encinal students.
3. We recommend in depth research on the more extreme effects of stress for teens, including drug and alcohol abuse, eating disorders, depression, etc..
4. We recommend further research on what students would do to relieve stress, such as after school programs/activities, workout sessions, organization lectures, etc.

OUR FINAL THOUGHTS

After doing this project....

- I know when I'm stressed
- I can tell when other people are stressed
- I feel helpful
- I am more aware
- I can pinpoint the sources of stress

It was important that we spent our time on this because...

- Stress affects everyday life, future, and health
- Stress affects *everyone*
- Stress leads to many more negative effects
- Stress affects *TEENS*
- Now we can help!

"The most valuable part of this project was meeting new friends and learning to work together and cooperate as a team."

-- Emily Chow

" The most valuable part of this project was learning things I didn't know before and meeting new people and working together as a group. It was interesting hearing people's ideas and thoughts."

-- Muzit Tzehaye

"I had worked with many different teen groups before, but none of them compare to the SRT. Researching was something new to me, and it was so exciting, understanding different types of survey questions. But one of the most valuable part of the project would have to be speaking in front of adults, not just about yourself but something you've worked hard on. I was always nervous we would get negative feedback. Thankfully, the hard work and having a great group paid off, we never heard a complaint!

-- Emily Fuentes

" The most valuable part of this project was knowing that I accomplished something that will help people."

-- Freshta Kohgadai

THANK YOU AND ACKNOWLEDGEMENTS

We would like to thank a few people for supporting us throughout this long process. We would like to thank Mr. Baer, Ms. Greig, Mr. Kahane, Ms. Mumford, and Ms. Sotello, the wonderful teachers that played the important role of distributing our surveys. We would also like to thank Xanthos, UCSF, Tri-High, Tamar, and Spenta for supporting us and providing us with the tools we needed. But most of all, we would like to thank Ariana for being a great coordinator, a great motivator, and a great friend!

This project and publication were supported by Grant Number R06/CCR921786 from the Centers for Disease Control and Prevention (CDC) and through the support of the University of California, San Francisco, Youth in Focus and the Alameda County School-Based Health Center Coalition. Its contents are solely the responsibility of the authors and do not necessarily represent the official views of CDC.

STRESS SURVEY

EHS Student Research Team

This survey was made to help Tri-High and the Student Research Team better understand stress at Encinal/Island. This is a confidential survey, so please answer these questions honestly. ***DO NOT WRITE YOUR NAME***. Thank you!

Love, Emily C, Emily F, Freshta, Haticia, and Muzit

1. School: Encinal Island

2. Age: 13 14 15 16 17 18 19

3. Grade: 9 10 11 12

4. Gender: Male Female

5. Race/Ethnicity: ***Please circle all that apply.***
   White/Caucasian African/African American Hispanic/Latino Asian
   Native American Hawaiian/Pacific Islander Middle Eastern Other _____

6. How much family support do you get when you are stressed?
   A lot of support Some support Little Support No support

7. A) Do you organize your time? (For example, do you keep an agenda or make lists?)
   Yes No

7. B) If yes, does it help you control your stress level?
   Yes No

8. How do you feel when you are stressed? ***Please circle all that apply.***
   a. Depressed
   b. Irritated
   c. Moody
   d. Sensitive
   e. Helpless
   f. Other _____

9. **Rank** from 1 – 5 (1= most likely, 5= least likely) who you would go to to talk about stress and for help.
   ___ Friends
   ___ Teacher/School Counselor
   ___ Parents/Family
   ___ Tri-High Counselor
   ___ No one

10. What do you do after school? ***Please circle all that apply.***
    a. Homework
    b. Chores or a job
    c. Relax
    d. Extracurricular Activities

11. **Rank** your priorities in order of importance. (1= most important, 4= least important)
    ___ School
    ___ Job and money
    ___ Social Status
    ___ Relationships (family/friends)

12. Which of these help you relax the most? ***Please circle ONE.***
    a. Hanging out with friends
    b. Keeping to myself
    c. Taking walks or exercising
    d. Listening to music
    e. I don't take time to relax

13. Are you aware of the effects of stress on your life?
    Yes No

14. **Rate** how much stress each of the following causes. (1= low amount of stress, 5= high amount of stress)

	Low				High
Parents	1	2	3	4	5
Peers	1	2	3	4	5
Teachers	1	2	3	4	5
Work/Schoolwork	1	2	3	4	5
Future Goals	1	2	3	4	5

15. When I'm stressed my grades begin to suffer.
    Strongly Agree Agree Disagree Strongly Disagree

16. When I'm stressed my relationships with friends and family suffer.
    Strongly Agree Agree Disagree Strongly Disagree

17. How does stress affect your health? ***Please circle all that apply.***
    a. Eat more
    b. Eat less
    c. Sleep more
    d. Sleep less
    e. Get sick
    f. Exercise more
    g. Exercise less

18. How often do you have time to relax in a school day?
    Very Often Often Not Often Never

19. How does stress affect your school life? ***Please circle all that apply.***
    a. I don't do homework or I ignore my studies
    b. I don't go to class
    c. I get distracted in class
    d. I get in trouble in class
    e. Stress doesn't affect my school life in these ways

20. How does stress affect your life the most *outside* of school? ***Please circle ONE.***
    a. I use drugs/alcohol
    b. I ignore responsibilities
    c. I treat friends/family badly
    d. I neglect my health
    e. I'm not aware of how stress affects my life outside of school

21. I am stressed out because I need things that my family and I can't afford.
    Strongly Agree Agree Disagree Strongly Disagree

22. A) My race causes stress in my life.
    Strongly Agree Agree Disagree Strongly Disagree

22. B) If you Agree or Strongly Agree with #22A, how does it cause you stress? ***Please circle all that apply.***
    a. I am singled out
    b. I get physically hurt
    c. I am always reminded of my race
    d. I feel like I need to prove myself

23. How do you control your stress? ***Please circle ONE.***
    a. I talk to people about it
    b. I limit my tasks
    c. I give up
    d. I continue on with my life
    e. I don't know how to control my stress

O_YEAH...

(Organized Youth Educating Adolescents on Health)

STUDENT RESEARCH TEAM

A STUDY ON ADOLESCENT SUICIDE AND ON SUPPORT SYSTEMS UTILIZED BY STUDENTS ON THE SAN LORENZO HIGH SCHOOL CAMPUS

TABLE OF CONTENTS

ABOUT O_YEAH

Mission of the San Lorenzo High Health Center

The mission of the San Lorenzo high Health Center is to support people needs like when they feeling stressed sad and angry, hurt, or mad. Provide students with access to medical and mental health care to assure that their healthy which will allow them to be better at school

O_YEAH Student Research Team (SRT)

The purpose of the SRT is to strengthen the role that the SLZ health center plays on this campus, of fostering healthy adolescents by finding out what supports students have in place when they feeling stressed, sad, angry, hurt, or mad and are considering or have considered suicide as a solution. By identifying and researching issues that effect students in the SLZ community. We will then provide recommendations to the school and San Lorenzo High Health Center and La Clinica de la Raza on how to improve the level of the services offered at the SLZ High School when dealing with students in crisis.

San Lorenzo High Health Center Services

There are many types of service at the San Lorenzo High Health Center like medical service, health education, counseling / therapy.

The kinds of mental health services available at the San Lorenzo High Health Center are:

- Alcohol & drug abuse counseling
- Case management
- Relationship counseling
- Crisis counseling
- Stress management / depression
- College and career counseling
- Family counseling
- Grief/ loss counseling

FACILITATOR STATEMENT

The San Lorenzo High Health Center has been dedicated to providing for and treating the whole individual. By providing a full range of services in a school based health center they are able to connect with a portion of our community that usually does not access health care. The providers as a collective believe that in order for adolescents to learn and grow to be a proactive individuals as well as educated members of the school community and of society they must be educated in all areas life.

It is this belief that lead the center to support, host and participate for a second year in a youth led research project focused on determining what supports students have in place that help them to understand that suicide is not the only option when they are in crisis. The University of California San Francisco's - Institute on Health Policy Studies provided the funding through a grant from the CDC as well as technical and moral support for this project. Youth in Focus an Oakland, California based youth advocacy program provided the curriculum and training for the youth researchers and project coordinator as well as continued support throughout the project. This project was also supported by the administration at San Lorenzo High School, La Clinica and the San Lorenzo Unified School District.

The O _YEAH youth researchers believed that they could make a change. With the support of all of the parties listed above they set out to find a solution to a concern and their work and dedication has brought some interesting findings and recommendations to light. It is through the voices of our youth that we together will build a stronger foundation for their tomorrow.

Leslie Robinson Davis
Project Coordinator

BIOGRAPHIES

My name is Jennifer Phung and I am 16 in the 11th grade. My nationality is part Vietnamese and part Chinese. I go to San Lorenzo high school, I love to go out on hot days with my friends. I love going shopping if only when I have money. I joined O_Yeah research team because I want to know more about what other teens really think about suicide, and what other teens have to deal with. I am a teen myself but I know there still more to it then I have already experienced. So I join the O_Yeah research team because I wanted to make a difference.

Hi. My name is Julia Moua and I am 16 years old. I am a sophomore at San Lorenzo High. How I knew about this program is from my friend. Her name is Jennifer and she is also a member of the O Yeah researcher team. She introduced me to this team, and ever since then I decided to stay and give a hand. I joined the O Yeah team because I needed to keep myself occupied, learn how to spend my time wisely, extend my vocabulary, and help others out. It has been a real great experience with all my team members and I had loads of fun along with work. Most of the time this job feels more like a hang out then a work place, because we have a lot of fun. I enjoy spending time with my team members and I hope to be in this team again next year.

BIOGRAPHIES

Hi, my name is Marla and I go to San Lorenzo High, I'm a freshman. I'm the one who brings fun to the SRT. I joined the SRT because I love to have new experiences and meet new people. I participated in this project too because, I wanted to help other students solve their problems, support them, and make them realize they're not alone in this world and other people have problems too. I'm always there when you need a friend. I think that's all I want people to know about me.

I'm Supreet Kaur, currently a freshman at San Lorenzo High School. I plan on going to medical school after high school to study anatomy and psychology. The reason I choose to participate in this project was so I could help out my community in my spare time. All the time we have put into this project has helped us learn so many new skills and given us many great experiences I will never forget.

EXECUTIVE SUMMARY

The purpose of this project is to find what resources students at San Lorenzo High have in place to help them deal with crisis situations that might leave them feeling depressed and / or suicidal. By surveying the students at San Lorenzo High about, "what supports they have in place when they are feeling hurt, sad, angry or mad?" we can make recommendations on how to improve these supports and make them aware of the other options that are available to them on this campus and in the community.

We found out that for the most part students use their friends as the primary resource when they are dealing with crisis situations. They also talk to their parents, mostly their moms. We found that students know about the health center and some of the services that are provided there. Based on our findings we decided that we wanted to create a "Teen Resource Guide" that includes the names and numbers of the different places that they can call for help when they are considering suicide or just feeling really depressed.

This topic is important to us because we go to this school and we understand some of the things that teens go through in high school. We also understand that sometimes friends even if they mean well can't always give the help that is needed.

METHODOLOGY

We started out with 5 members but one never showed up. So we ended up with 4 members. We often meet on Wednesdays and sometime on Fridays, for 1 ½ hour each time. The way we picked our topic by starting out with many subjects that we all were interested in. Our research group sat together and picked out the one that we all wanted. The information that we used to help us was make or choice was our own experiences and seeing other people who were depressed on campus. We also started brainstorming and writing ideas down on paper. We chose suicide because every drama for SLZ High School students leads to depression and suicide becomes an option. Things like family, school, $, friends and drugs. To decide our research question all 4 of us had 4 big pieces of paper and we started to think about our question. We also had Mrs. Rob, Ahna and Samira to guide us while we brain stormed on what the focus of our research would be.

We chose to use a survey as our research tool, because we felt that was the fastest way to get 300 students to answer 20 questions in 10 minutes. It also provided us with the information we needed to accurately assess how student handle stress and daily life. We conducted our research by asking students at all grade levels to fill out the survey at break, lunch, and sometimes we interviewed them during class time. We collected our data by getting information from students. After we were done collecting all the data we entered it in to Survey Monkey. Survey Monkey added up our results and provided our data set. Using the data set we selected the top issues, narrowed it down to three. These are what we used to make our recommendations.

DATA ANALYSIS

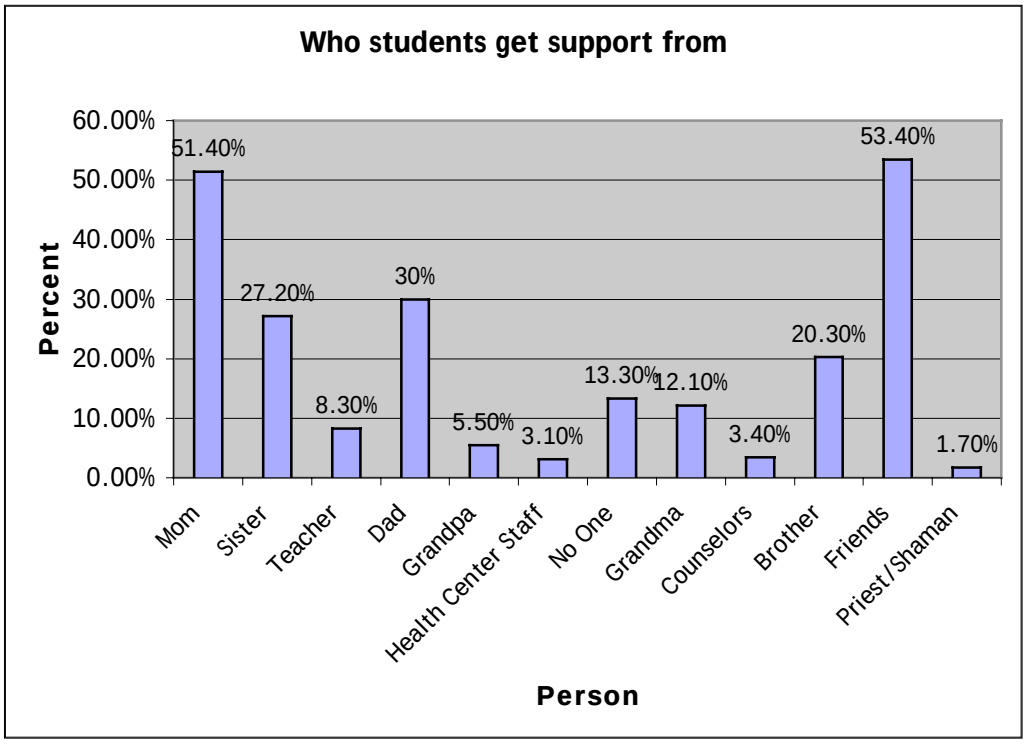
Student Supports

These are a couple of findings from our data that caught our attention, along with these supporting data and graphs.

Even though students have support at home from both their mom and friends, they prefer their friends for support when feeling sad, mad, angry, or depressed.

Supporting data:

1. 54.1% of the students said their mom support them at home when they have a problem.
2. 53.4% of the students said their friends support them at home when they have a problem.
3. 58.8% of the students prefer to go to their friends for support.
4. Only 29.8% of the students go to their mother for support.



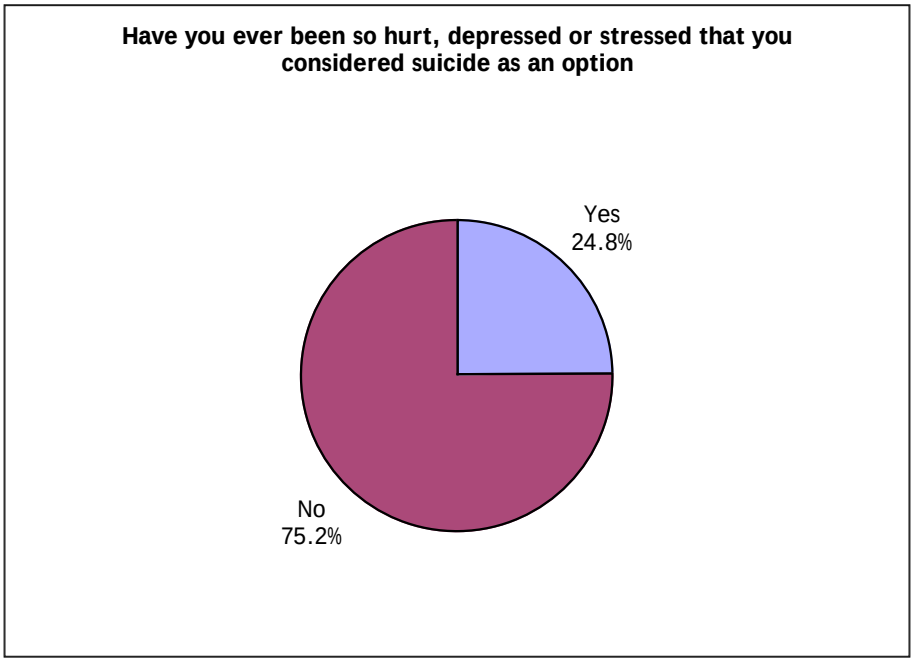
DATA ANALYSIS
Student Stress

Finding #2:

Despite the fact that students have support, they still stress out at least once a week, and some think about attempting suicide due to a lot of these barriers.

Supporting data:

1. 61.6% of the students stress out at least once a week.
2. The top 3 stressors; 63.3% are stressing over school, while 31.8% are stressing over family, and 29.7% are stressing over physical/relationship.
3. 24.8% of the students consider attempting suicide.

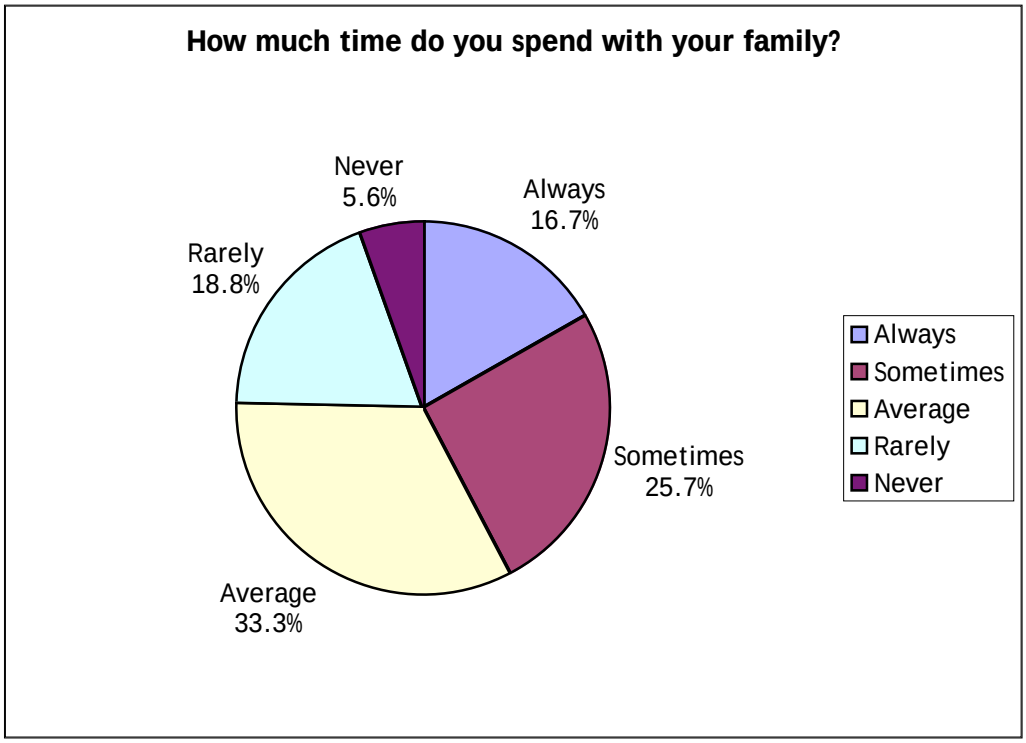


DATA ANALYSIS
Time Spent With Family

Finding #3:
Most of the surveyed student live with their parents, spend about average time with their families, and receive more support from their mother.

Supporting data:

1. 55.3% live with mom and dad
2. 33.3% of the students spend about average time with their family.
3. 54.1% of these students mother support them when they have a problem



LIMITATIONS AND LESSONS LEARNED

Through out the project we made many mistakes and learned from them. There were times we felt didn't know what we were doing. By and by as the project of the Student Research Team grew we realized the entire thing we can do or change, so perhaps next time our results will be better and detailed.

- We could have detailed and made our questions on the survey more clearer and specific so the readers knew our exact meaning
- Maybe we all could have attended the meetings regularly
- We could have put more time into the project, maybe had more frequent meetings
- We could have made a pilot survey to try out.

Things learned:

- We learned how to brainstorm, select a topic, see if the topic had enough depth to be researchable
- Prior to beginning this project, we discovered the high number of the teen suicide, and found that this is not a new fad in how students deal with stress.
- We learned how to develop a research tool that would allow accurately access how the students at SLZ deal with stresses of everyday life
- When the time came for data entry we received training on using survey monkey, an online server that allowed us to enter survey content and provided us with immediate statistics
- We learned that by analyzing these results we could make sound recommendations in areas of providing mental health support to students in crisis.

THANK YOU'S

We want to thank everyone at the Health Center for helping us with this project and for caring about teens. Thank you to Ahna for the fun games at our meetings and for teaching us how to do a research project. Thank you to Samira for always bringing our money on time and for having fun with us while we learned new skills. A special thank you to Victor for sharing his knowledge with us about teens and how they deal with stress. And to Ms. Rob for the great (healthy) snacks, guiding us and making us do this on our own.

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Tri-Valley Adolescent Health Initiative
Regional Research Findings Report

Produced by
Tri-Valley Adolescent Health Initiative

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School Health Services Coalition's Tri-Valley Adolescent Health Initiative

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I. INTRODUCTION

What is the Adolescent Health Initiative?

Launched in May 2005, the Tri-Valley Adolescent Health Initiative (TVAHI) is a joint project between Alameda County Supervisor Scott Haggerty, the Cities of Dublin, Livermore and Pleasanton, and the Alameda County Health Care Services Agency's School Health Services Coalition. These key partners created the Tri-Valley Youth Planning Board (YPB), which includes youth representatives from each city, to help identify and address health concerns of local youth. The goal of the Tri-Valley Adolescent Health Initiative is to improve access to and expand health and wellness services for adolescents in the Tri-Valley region. The Alameda County Board of Supervisors allocated ongoing Measure A funds to support the development of school-linked health services for adolescents in the Tri-Valley.

What is the Purpose of this Report?

The purpose of this report is to present a summary of the assessment data that the Youth Planning Board collected and analyzed through the first year and a half of the project, with assistance from the Alameda County School Health Services Coalition and the University of California San Francisco Institute for Health Policy Studies.

The report will be distributed to key adult stakeholders for informational purposes and as an important tool for engaging these stakeholders in the next round of planning discussions. Key adult stakeholders include parents, healthcare providers and city, school and county officials. The next rounds of planning discussions will focus on working with adult stakeholders to develop a regional infrastructure to support this project, to evaluate the feasibility of implementing youth recommendations and to craft an action plan for beginning to implement youth recommendations. Youth will continue to play an integral role in providing direction and technical assistance through the duration of this project.

What is the Youth Planning Board?

The Tri-Valley Youth Planning Board (YPB) is a group of youth who have joined together to help identify and address major health concerns for youth in the Tri-Valley. Formed in October 2005, the YPB has had representatives from grades 8 through 12, from Las Positas Community College, and from all three Tri-Valley cities. The YPB participants have been selected through the Tri-Valley city youth commissions and city councils. The YPB has spent the first 15 months meeting bi-weekly to discuss possible health concerns for adolescents, creating a survey to help identify the major health issues, administering the survey to 7,000 middle and high schools throughout the Tri-Valley and conducting focus groups with their peers to provide further context to their findings. This report presents a summary of the major research findings from the YPB assessment as well as youth recommendations for improving teen health.

II. RESEARCH METHOLODOLOGY

Researchers

The Tri-Valley Youth Planning Board (YPB) worked in collaboration with the Alameda County School Health Services Coalition and the University of California San Francisco Institute for Health Policies Studies to engage a broad cross section of youth in a regional participatory assessment of youth health and wellness needs in the cities of Dublin, Livermore, and Pleasanton.

Data Sources & Methods

Three primary existing data sources were used in the assessment process: the California Healthy Kids Survey (CHKS), the Tri-Valley Health Profile (TVHP), and the California Physical Fitness Report (CPFR). To supplement existing data, two original research projects were conducted by the YPB to collect in-depth information. These original research projects were Tri-Valley Student Health Survey (TVSHS) and the Tri-Valley Focus Groups (TVFG). A description of the data sources and methods is as follows:

- ***Tri-Valley Student Health Survey (TVSHS)***

  The student survey was developed by the YPB to learn more about the health and wellness issues among community youth, with an emphasis on youth most in need of support. The TVSHS was administered at area middle, high and continuation schools in spring 2006. The vast majority of results used in this presentation, the topic-specific fact sheets and planning efforts are based on the 1,365 10^{th} graders, 646 12^{th} graders and 231 continuation students (all grades) that took the survey and said that they answered the questions honestly. The results were weighted to represent what we would expect to see if all Tri-Valley 10^{th} graders, 12^{th} graders and students from continuation schools had taken the survey. These methods were selected to provide us with valid comparisons between the cities, as 9^{th} and 11^{th} grade information was not available for all cities and student response rates varied considerably by city. Comparisons between gender and race/ethnic groups were unweighted and based on surveys from the 4,264 high school students. Middle school comparison data is available only for Pleasanton and the 1,480 responses were weighted to represent all 2,173 middle school students in Pleasanton. Copies of the high school and middle school surveys are attached.

- ***Tri-Valley Focus Groups (TVFG)***

  Focus groups were held in spring and fall 2006; the questions were designed and conducted by youth facilitators and staff. In spring 2006 focus groups were conducted with 28 youth from support groups and continuation schools to learn about what makes a service "youth friendly." Focus group results were used to in the creation of the YPB's *That One Place* resource guide. The fall 2006 focus groups were conducted with 67 youth from support groups, continuation schools and a Regional Youth Summit open to all Tri-Valley youth. The fall 2006 focus groups were conducted to collect richer detail about the context of the teen health issues described in the topic-specific fact sheets and to begin documenting youth ideas to address these issues. The recommendations shared at this meeting reflect the broad categories that capture the more specific ideas that received the most votes from the 67 youth that participated in our fall 2006 focus group and prioritization process.

- ***California Healthy Kids Survey (CHKS)***
  Student survey administered every other year to 7th graders, 9th graders, 11th graders and continuation students (all grades) in California. The results used in this assessment are from the 2003-2004 school year, the most recent data that was available when we reviewed the existing data. The Tri-Valley data is based on the 1,825 7th graders, 1,592 9th graders and 1,359 11th graders that took the survey (continuation students data was not available). The results were weighted to represent all 7th, 9th and 11th graders in the Tri-Valley and results are presented separately for each grade level.

- ***Tri-Valley Health Profile (TVHP)***
  This 2005 profile was prepared by the Alameda County Public Health Department's Community Assessment, Planning and Education (CAPE) Unit and contains information on a variety of health indicators including teen births and sexually transmitted infections.

- ***California Physical Fitness Report (CPFR)***
  This report presents annual test results for California students to learn more about youth overweight and fitness. At the time of our assessment, the most recent results were from the 04/05 school year. Overweight was defined through body fat measurements and body mass index. Aerobic fitness was determined through tests for running and walking. The Tri-Valley results presented in this report are based on the 2,488 local 7th graders and 2,693 local 9th graders that were tested during the 04/05 school year.

Research Limitations

As with any assessment project, there are a number of limitations to keep in mind when interpreting outcome data. A description of key limitations in the Tri-Valley Adolescent Health Initiative assessment process is presented as follows:

Cultural and Ethnic Representation

The members of the Youth Planning Board who initiated this process were not representative of the Tri-Valley students in greatest need. The Year 1 members of the Youth Planning Board were all high achieving young people with previous leadership experience who came predominantly from supportive and affluent families. All of the Year 1 YPB members were White and nearly all were high school (versus middle school or community college) students. The YPB remained aware of their cultural bias throughout the process and efforts were made to survey a broad cross-section of youth, including students at continuation schools. Staff and youth facilitators conducted focus groups to collect more detailed information about the needs of diverse students, including those in continuation schools and youth support programs. In recruiting for its Year 2 membership, the youth planning board made an effort to recruit students from diverse backgrounds and experiences.

Many Statistics Not Included in Summary

Throughout the assessment, the YPB collected huge amounts of information and it is important to note that this presentation and the attached documents present only the highlights. Key statistics were not included in these summaries for a variety of reasons: the YPB felt the information was less important or compelling than what was included in the summary (i.e., tobacco, home cooked meals), the information was only available or we were only able to access the information for one Tri-Valley city versus the region as a whole (i.e., sexual activity, student-to-counselor ratios), the information was not available and we were not able to collect it due to confidentiality concerns (i.e., abuse, teen pregnancies). Please note that other more detailed documents will be released in the upcoming months: a project report,

which will share more detailed information about the youth recommendations and sub-recommendations, and city-specific summaries of the survey findings.

Looking at Differences between Groups

This report relies on statistical significance to highlight disparities between groups. It is important to note that confidence intervals are wider when there is a small number of cases (we are 'less sure' that these cases represent a true pattern), so groups with small population size, such as Middle Eastern and African American students, are less likely to be highlighted as being statistically different. This does not always mean that there are no true differences or disparities experienced by these groups.

City-Level Estimates May Look Different in Regional vs. City-Specific Reports

As noted in the methods section, the regional survey results look primarily at the weighted responses of 10^{th} and 12^{th} graders from comprehensive schools and students from continuation schools to create a regional estimate. This was done because we had information from these groups from all three cities and this was the most valid way for us to evaluate differences between cities. Please note that for two cities, additional responses from 9^{th} and 11^{th} graders are added-in to the city-level summaries of the raw survey data which may cause them to differ slightly from the regional estimates for that city.

Number of Youth Focus Group Participants

Though we worked hard to involve a large number of young people, we were able to engage only 67 in our focus group process. Though we did engage youth from all three cities, from multiple grade levels and from multiple ethnic groups, there may be additional types of subgroups that were not well-represented in our process.

Focus Groups Process

The focus group discussions were conducted around four health topic areas: substance abuse, mental health (including violence and life planning), reproductive health and other physical health issues (including nutrition and exercise and access to medical care). If the groups had been conducted in a different format, the results may have been very different. We expect that the groups would have spent different amounts of time on each topic, and even skipped some of the topics, if no buckets were used to guide the discussions. Other issues like transportation may have emerged more strongly if they were a separate topic for focused discussion.

Unanswered Questions

The Youth Planning Board collected huge amounts of very important information through their assessment process; however, it is anticipated that there will be many places in which the collected data will prompt further questions. This is natural and an inherent part of any assessment process. The next step is to convene key stakeholders, identify decisions that can be made with the data at hand and decide on an open and participatory process for decision-making. The stakeholders can then to hone-in on any other specific information that they would like to pursue for informing subsequent decisions to be made.

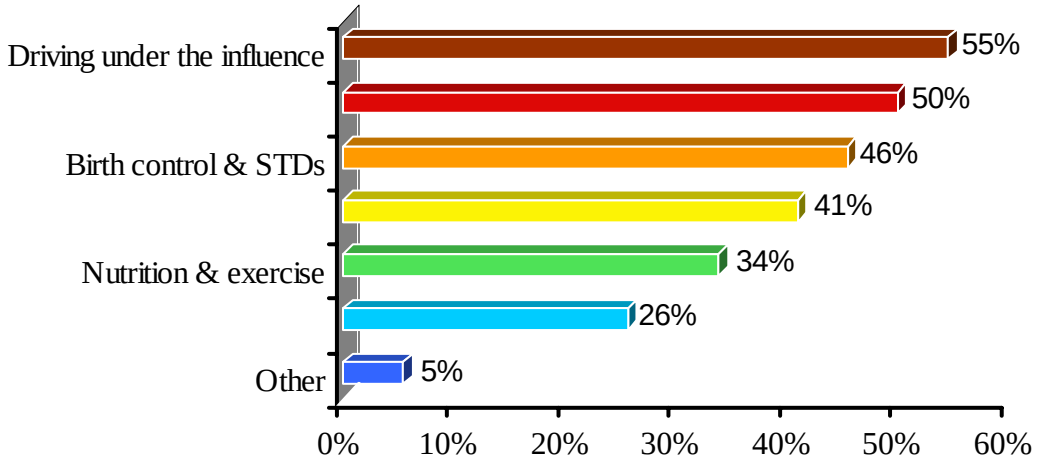
III. KEY FINDINGS

Overarching Findings

Top Health Issues

The YPB's spring 2006 Tri-Valley Student Health Survey (TVSHS) asked students to identify the topics that they felt were very important among students at their school. As shown below, 'driving under the influence,' 'alcohol and drug use,' 'birth control and STDs' and 'stress and depression' were identified as the top health topics. Examples of 'Other' write-in responses included violence, anger management, relationship abuse, stereotyping, rape, peer counseling, sexual activity, self-mutilation, respect, domestic violence,

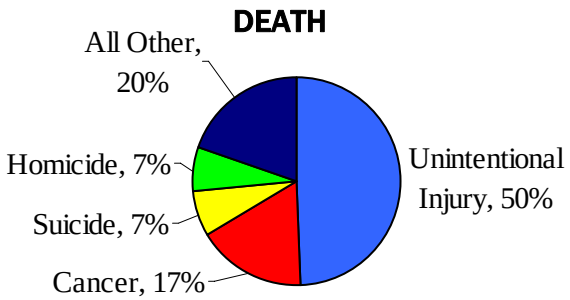
Percent that considered the following health topics very important among students at their school.



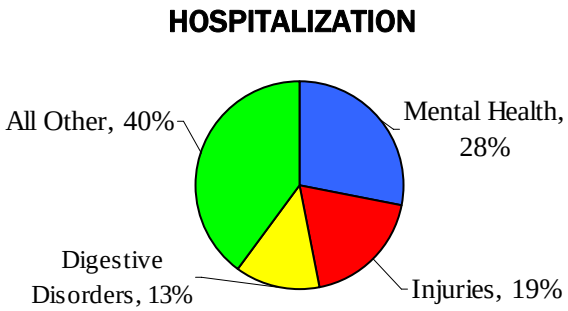
Leading Causes of Death and Hospitalization

According to the Alameda County Public Health Department's Community Assessment, Planning and Education (CAPE) Unit, the leading causes of death among Tri-Valley youth age 15-24 years were unintentional injuries and cancer. Car crashes accounted for the bulk (73%) of unintentional injury deaths. The leading causes of non-fatal hospitalization excluding childbirth were mental health issues including depression and substance abuse, injuries including unintentional, self-harm and assault, and digestive disorders including ulcers and appendicitis. Car crashes accounted for 31% of non-fatal injury hospitalizations.

Leading causes of death and hospitalization among Tri-Valley youth age 15-24 years, 2001-2003.



(n = 30)

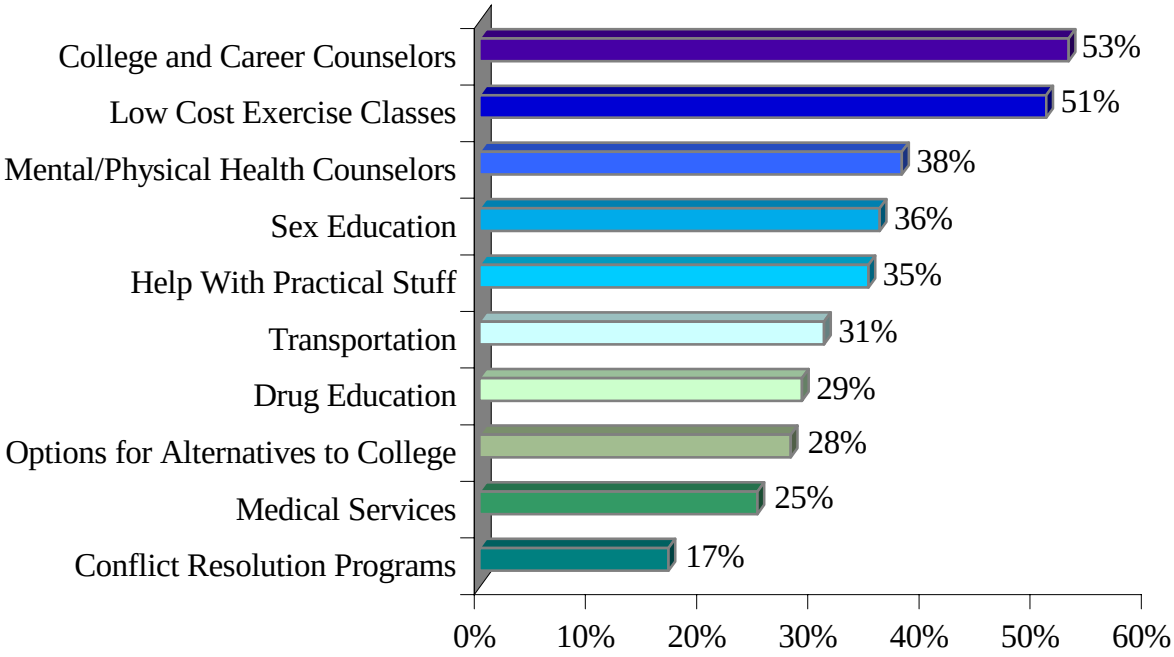


(n = 1,356)

Most Requested Resources

The TVSHS also asked students to give examples of the health and wellness resources that they would like to see more of in their school or community. The top three resources identified by students were college and career counselors, low cost exercise classes and mental/physical health counselors.

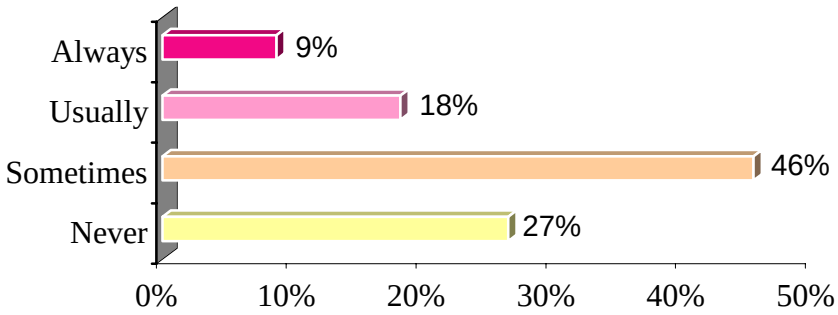
Percent that wanted to see more of the following resources in their school or community.



Transportation Barriers

A third overarching finding has to do with transportation barriers in the Tri-Valley, which is a geographically large region covering 60 square miles of land. Transportation barriers can limit a young person's ability to travel to health services and can particularly impact access to confidential mental health and family planning services if the adolescent needs to ask a parent, other adult or friend for a ride. The graph below shows the proportion of TVSHS respondents that said that transportation always, usually, sometimes or never keeps them from doing things they want to do.

How often does transportation keep you from doing things you want to?



Introduction to the Health Topic Fact Sheets

The following fact sheets were created by the Tri-Valley Youth Planning Board, with assistance from project staff. The purpose of the fact sheets was to draw together data from a variety of sources including the Tri-Valley Student Health Survey (TVSHS), the California Healthy Kids Survey (CHKS), the California Physical Fitness Report (CPFR), the Tri-Valley Health Profile (TCHP) and the California Health Interview Survey (CHIS). Please see the Research Methodology Section for more information about these sources. To provide additional context, some Youth Planning Board Quotes and School District Staffing Statistics are also included. The fact sheets center on four core teen health issues and were used to kick-off discussions in the fall 2006 focus groups.

Major Findings by Topic Area

SUBSTANCE USE… includes driving under the influence, alcohol/drug abuse, and tobacco use

- The majority of Tri-Valley youth reported driving under the influence as a very important health issue among students at their schools.
- The proportion of Tri-Valley youth that have driven under the influence varies widely between different groups.
- Tri-Valley Youth drink and use drugs to have fun, to escape stress and boredom and to fit in.
- Many Tri-Valley youth drink alcohol and experiences with alcohol use and abuse are slightly higher in the Tri-Valley than in Alameda County as a whole.
- Tri-Valley students would like more drug education services.
- Some Tri-Valley youth smoke despite being aware that cigarettes are harmful to their health.

REPRODUCTIVE HEALTH… includes sexual activity and birth control and STDs

- Though Tri-Valley youth note the importance of waiting to have sex, many feel uncertain that they could say no to a partner that wanted to have sex.
- One fourth of Tri-Valley youth did not always get help when needed for confidential reproductive health issues.
- The percentage of youth that do not always get needed reproductive health care varies between groups.
- Though less of an issue locally than countywide, some Tri-Valley youth do get pregnant and are diagnosed with STDs.

MENTAL HEALTH… includes mental health and violence

- Many Tri-Valley youth do not receive counseling to help deal with issues, such as stress and depression.
- Academics, plans for the future and family are all major contributors to stress among Tri-Valley youth.
- The majority of youth do have at least one person they can talk to about major health issues.
- Some youth have experienced discrimination at school.
- Many Tri-Valley youth experience safety issues at school.

PHYSICAL HEALTH… includes physical health and nutrition and exercise

- Over one third of Tri-Valley youth said that they did not always get needed medical care when they were sick or hurt.
- Tri-Valley youth want more low-cost exercise classes and more healthy affordable food options at school.
- Some Tri-Valley youth get very little or no exercise outside of school.
- In the Tri-Valley, one fourth of youth are overweight and one fourth did not meet the state's standards for aerobic capacity.

A Look at *Substance Abuse* among Tri-Valley Youth

- **The majority of Tri-Valley youth reported driving under the influence as a very important health issue among students at their schools.**
  - 55% said that driving under the influence was a very important health issue. (TVSHS)
  - 14% had driven under the influence of drugs and/or alcohol. (TVSHS)
  - 35% had been in a car with a driver under the influence of drugs and/or alcohol. (TVSHS)
  - 8% rarely or never secure a sober driver when they go out with their friends and plan on being under the influence. (TVSHS)

- **The proportion of Tri-Valley youth that have driven under the influence varies widely between different groups, such as continuation students and males.**
  - 28% of continuation students have driven under the influence versus 21% of 12th graders and 6% of 10th graders from comprehensive schools. (TVSHS)
  - 14% of males versus 9% of females have driven under the influence. (TVSHS)
  - 32% of 11th graders in the Tri-Valley had driven after drinking alcohol or driven with a friend who had been drinking alcohol versus 26% of 11th graders countywide. (CHKS)

- **Tri-Valley Youth drink and use drugs to have fun, escape stress and boredom and to fit in.**
  - 50% said that alcohol and drug use was a very important issue among students at their school. (TVSHS)
  - African Americans (64%) were more likely than Whites (49%) to consider alcohol and drug use a very important health topic at their schools. (TVSHS)
  - The top three reasons teens reported using alcohol and/or drugs were that they enjoy the feeling it gives them (67%), stress (49%), boredom (46%) and to fit in (46%). (TVSHS)
  - Youth in Dublin (53%) and Livermore (52%) were significantly more likely than those in Pleasanton (45%) to report that they considered stress a top reason why students use drugs and/or alcohol. (TVSHS)

- **Many Tri-Valley youth drink alcohol. Experiences with alcohol use and abuse are slightly higher in the Tri-Valley than in Alameda County as a whole.**
  - 35% of Tri-Valley 11th graders drank alcohol and 21% binge drank in the past month. Binge drinking is defined as five or more drinks in one sitting. 39% of Tri-Valley 11th graders had ever been drunk or very sick after drinking alcohol. (CHKS)
  - The proportion of 11th graders that drank alcohol in the past month, binge drank in the past month and had ever been drunk or very sick after drinking alcohol were all slightly lower in Alameda County (33%, 18% and 35%) and significantly higher in California (41%, 26% and 43%) compared to rates in the Tri-Valley region. (CHKS)
  - The proportion of students that drank alcohol and binge drank in the past month increased greatly from 7th to 11th grade. (CHKS)
  - "When adolescents drink, they do not drink in small amounts, they drink large amounts for the sole purpose of getting drunk. Every weekend in the Tri-Valley there is almost always a party at someone's house where there will be underage drinking." (YPB quote)

❖ **Tri-Valley students would like more drug education services.**

- 29% said they would like to see more drug education services in their school or community.
- 40% of continuation students requested more drug education services versus 32% of 12th graders and 25% of 10th graders from comprehensive schools. (TVSHS)
- 29% of 11th graders in the Tri-Valley had ever been high versus 31% countywide and 41% statewide. (CHKS)
- Top drugs used by students are marijuana, ecstasy, cocaine and shrooms. (TVSHS)
- 15% of Tri-Valley 11th graders reported using marijuana in the past month. (CHKS)
- Marijuana and other drug use increase greatly from 7th to 11th grade. (CHKS)

❖ **Some Tri-Valley youth smoke despite being aware that cigarettes are harmful to their health.**

- 14% of 11th graders in the Tri-Valley had smoked cigarettes in the past month versus 12% countywide and 19% statewide. (CHKS)
- Approximately 3% of Tri-Valley 7th graders, 8% of Tri-Valley 9th graders and 14% of Tri-Valley 11th graders have smoked cigarettes in the past month. (CHKS)
- 97% of 7th, 9th and 11th graders perceived smoking cigarettes frequently as being harmful to their health. (CHKS)

A Look at *Reproductive Health* among Tri-Valley Youth

- **Though Tri-Valley youth note the importance of waiting to have sex, many feel uncertain that they could say no to a partner that wanted to have sex.**
  - 60% of respondents think they should have a partner they trust and love before they have sex and 45% think that they should be married before they have sex. (TVSHS)
  - 33% of respondents feel that they should wait until they can talk to their partner about protection before they have sex. (TVSHS)
  - 25% of respondents reported that if they had a boyfriend/girlfriend that wanted to have sex, they were not sure whether they could say no to their partner. (TVSHS)
  - 37% of males versus 10% of females said that they were not sure they could say no to a boyfriend/girlfriend that wanted to have sex. (TVSHS)

- **In California, one quarter of teens have been sexually active and, of these, nearly half did not use a condom the last time they had sex.**
  - 26% of California adolescents ages 12-17 years have been sexually active. Of these, 45% did not use a condom the last time they had sex. As of fall 2006, there is no regional or county-level data available about sexual activity or condom use among teens. (CHIS)

- **One fourth of Tri-Valley youth did not always get help when they needed it for confidential reproductive health issues.**
  - 46% of respondents considered birth control and STDs a very important health topic among students at their school. (TVSHS)
  - 26% said that they never (17%) or only sometimes (9%) received care when they needed it for help with confidential issues like birth control and STDs. (TVSHS)
  - 36% said that they would like to see more sex education resources in their school or community. (TVSHS)
  - When asked about the top barriers that sexually active students at their school face in using condoms and other forms of birth control, 37% checked ‘think it won’t feel as good,’ 28% checked ‘embarrassment,’ 17% checked ‘pressure not to use’ and 17% checked ‘money.’ (TVSHS)

- **The percentage of youth that do not always get needed reproductive health care varies between groups.**
  - 40% of Latino and 35% of Pacific Islander students, versus 23% of White students, said that they never or only sometimes received needed help with confidential issues like birth control and STDs. (TVSHS)
  - 39% of continuation students, versus 26% of all students, said they never or only sometimes received needed help around these confidential issues. (TVSHS)
  - 50% of Latino students versus 31% of White students wanted to see more sex education resources in their school or community. (TVSHS)
  - 47% of continuation students versus 36% of all students said that they wanted to see more sex education services. (TVSHS)
  - 37% of females versus 28% of males requested more sex education resources. (TVSHS)

❖ **Though less of an issue locally than countywide, some Tri-Valley youth do get pregnant and are diagnosed with STDs.**

- Each year there are approximately 73 births to Tri-Valley youth age 15-19 years. (TVHP)
- There are also roughly 56 cases of Chlamydia, the most common STD, and 5 cases of Gonorrhea diagnosed each year among Tri-Valley youth age 13-19 years. (TVHP)
- Rates of teen births and STDs are far lower in the Tri-Valley than in Alameda County as a whole. (TVHP)

A Look at *Mental Health* among Tri-Valley Youth

❖ **Many Tri-Valley youth do not receive counseling to help deal with issues, such as stress and depression.**

- 44% said that they only sometimes (15%) or never (29%) received counseling when they needed it to help deal with issues like stress, depression, or family problems. (TVSHS)
- 38% said they would like to see more "counselors to help with mental and physical health issues." Write-in answers specified counselors, peer counselors or support groups. (TVSHS)
- The Institute of Medicine's recommended student-to-counselor ratio is 250-to-1. Most Tri-Valley schools have triple this ratio of students-to-counselors. (School District Data)

❖ **Academics, plans for the future and family are all major contributors to stress among Tri-Valley youth.**

- 41% said that stress and depression was a very important health topic among their peers. (TVSHS)
- 30% of Tri-Valley 11th graders experienced depression in the past year. They felt so sad and hopeless everyday or almost everyday for at least two weeks that they stopped doing some usual activities. (CHKS)
- 27% said that they had ever seriously thought about hurting themselves on purpose. (TVSHS)
- Respondents identified academics (71%), future (56%), family (45%) and lack of time (42%) as the biggest causes of stress in their lives. (TVSHS)
- Students from continuation schools were far more likely to identify family (58%) and far less likely to identify academics (37%) as a top cause of stress in their lives. (TVSHS)
- In Pleasanton, the proportion of students that identified their future a major cause of stress in their lives increased with grade-level from 29% among 6th graders to 63% among 12th graders. We do not have middle school data from Dublin or Livermore. (TVSHS)
- In terms of resources, 53% said they would like to see more college and career counselors and 36% said they'd like more help with practical stuff. (TVSHS)
- 50% of students from continuation schools, versus 28% of all students, said they'd like more options or classes for people who aren't interested in going to college. (TVSHS)

❖ **The majority of youth do have at least one person they can talk to about major health issues.**

- When asked who they would talk to about major health issues/concerns, 97% said at least one person on our list and only 3% didn't specify anyone they could talk. (TVSHS)
- 73% said they would talk to friends, 65% to parents or guardians, 48% to doctors and 31% to siblings. A much smaller proportion (9-13%) checked counselors, coaches and teachers. (TVSHS)
- 66% of males versus 83% of females said they would talk to a friend about major health issues. (TVSHS)
- 47% of Middle Eastern, 54% of Latino and 64% of Multiethnic students would talk to their parent/guardian about major health issues versus 70% of White students. 49% of continuation students would talk to a parent/guardian about major health issues versus 66% of 10th graders and 68% of 12th graders. (TVSHS)
- Only 30% of continuation students said that they would talk to their doctor about major health issues versus 45% of 10th graders and 55% of 12th graders from comprehensive schools. (TVSHS)

❖ **Some youth have experienced discrimination at school.**

- 82% of respondents felt that the majority of the students at their school accepted them for who they are, and 14% did not feel accepted by their peers. (TVSHS)
- 31% said that they have ever felt discriminated against at school based on appearance, 25% based on social group, 22% based on race/ethnicity and 20% based on intelligence. A much smaller proportion (5-10%) had experienced discrimination based on gender, sexual orientation or other factors. (TVSHS)
- 58% of Middle Eastern, 56% of African American, 50% of South Asian, 45% of Latino, 33% of Pacific Islander and 28% of Multiethnic students reported having experienced discrimination based on their race/ethnicity at school compared to only 9% of White students. (TVSHS)

❖ **Many Tri-Valley youth experience safety issues at school.**

- 17% said that they would like to have more conflict resolution programs in their school or community. 24% of students in Dublin reported the need for conflict resolution programs versus 16% in Livermore and 16% in Pleasanton. (TVSHS)
- 24% of Tri-Valley 7^{th} graders have been in a physical fight at school in the past year, 28% have been afraid of being beaten-up and 32% have been harassed at school in the past year because of race, ethnicity, religion, gender, sexual orientation or disability. (CHKS)
- 7^{th} graders were slightly more likely than 9^{th} or 11^{th} graders to report these experiences. (CHKS)
- 9% of 7^{th} graders report that they have ever belonged to a gang and 9% report that they have carried a weapon to school in the past year. A smaller proportion (4%) report they have carried a gun to school. (CHKS)
- The proportion of 7^{th} graders that have been in a physical fight at school, belonged to a gang and carried weapons to school is similar in the Tri-Valley and Alameda County as a whole. (CHKS)

A Look at *Physical Health* among Tri-Valley Youth

- **Over one third of Tri-Valley youth said that they did not always get needed medical care when they were sick or hurt.**
  - 38% of respondents said that they sometimes (33%) or never (5%) received needed medical care in the past year when they were sick or hurt. (TVSHS)
  - Middle Eastern (54%) and Latino (45%) students were significantly more likely than White (33%) students to report that they only sometimes or never received needed medical care when they were sick or hurt. (TVSHS)
  - Most respondents said that they usually get medical care at either Kaiser (35%) or Valley Care (23%). (TVSHS)

- **Tri-Valley youth want more low-cost exercise classes and more healthy affordable food options at school.**
  - 51% said that they would like to see more "low cost exercise classes" in their community. (TVSHS)
  - If healthy foods were available at school for a reasonable price 72% of students would buy them. (TVSHS)
  - "The problem is that the healthy food costs so much more than the junk food. Many kids don't want to pay the extra money for something that may be somewhat healthier for them." (YPB Quote)

- **Some Tri-Valley youth get very little or no exercise outside of school.**
  - 39% said that they do not get ANY (8%) or that they get three or fewer (31%) hours of exercise each week outside of school. (TVSHS)
  - 36% of these students that get only three or fewer hours of exercise outside of school per week wanted more low-cost exercise classes. (TVSHS)
  - 45% of females versus 29% of males said that they get three or fewer hours of exercise each week outside of school. (TVSHS)
  - 52% of South Asian, 51% of Latino and 49% of East Asian students, versus 32% of White students, said that they get three or fewer hours of exercise each week outside of school. (TVSHS)

- **In the Tri-Valley, one fourth of youth are overweight and one fourth did not meet the state's standards for aerobic capacity.**
  - 34% identified nutrition and exercise, the major contributors to overweight, as a very important health topic among youth at their school. (TVSHS)
  - In the Tri-Valley, 25% of 9th graders were overweight and 25% did not meet the state's standards for aerobic capacity. (CPFR)
  - In Alameda County and California, the proportions of 9th graders that were overweight (29% and 33%) and aerobically unfit (44% and 49%) were significantly higher than in the Tri-Valley. (CPFR)
  - The proportion of 9th graders that were overweight was significantly higher in Livermore (30%) and Dublin (29%) than in Pleasanton (20%). The proportion that were aerobically unfit was also slightly higher in Livermore (26%) and Dublin (27%) than in Pleasanton (23%). (CPFR)

IV. Youth Recommendations

Introduction to Youth Recommendations

How they were developed

The following recommendations were created by the 67 Tri-Valley youth that participated in the fall 2006 focus groups. Please see the Research Methodology Section for more information about the fall 2006 focus groups. The purpose of these recommendations is to provide suggestions from the youth perspective about what could be done to successfully improve youth health and wellness in the Tri-Valley.

The broad recommendations were formulated as wide headings that captured the most popular youth ideas from the fall 2006 focus groups. The detailed recommendations include concrete examples that were generated from the focus groups, both the most popular ideas that received a large number of votes, as well as other ideas that provided more detail or context around the popular ideas or gist of the group conversations. The detailed recommendations are meant to provide some general direction to future committees working on these issues, but they are by no means conclusive. We expect that some of the detailed recommendations will change and grow based on adult input around feasibility and further youth conversations around these broad categories of recommendations.

How they are intended to be used

The broad recommendations are meant to inform planning and programming efforts under the four core teen health issues listed in the health topic fact sheets: substance abuse, reproductive health, mental health and physical health. As a best practice, it is recommended that work under each health topic area consider each of the broad recommendations developed by youth and be informed further by the detailed recommendations that were identified under that health topic area through the fall 2006 focus groups.

Please note that it isn't realistic to implement all recommendations under all topic areas within the first few years of joint (i.e., youth and adult stakeholder) planning efforts. Instead, the Initiative is recommending a staged approach to implementation.

Broad Recommendations from Youth

Peer Support

- ✪ Create youth-led peer education and outreach programs to teach students how to support and approach their peers around teen issues, such as substance abuse, sexual activity and mental health because youth are most willing to talk to and listen to people their own age.
- ✪ Create an effected mentorship program to connect freshman and transfer students to the High School environment.

Guiding Principals

- Peers should be informed about resources and how to respond
- Peer educators should be able to inform peers about teen rights and minor consent
- Teens with first hand experience are the best people to share stories and real life consequences

Parent Support

- ✪ Educate parents about the reality that affects teens today and reasons, signs/symptoms, and consequences of substance abuse, sexual activity, and mental health.
- ✪ Provide parents with non-judgmental tools to communicate openly with their teens and how to react to specific situations in order to deal with issues that apply to teens today.

Guiding Principals

- Parents need strategies to connect with their children on sensitive issues
- Parents need an educated nonjudgmental approach… stress making good decisions; don't say "don't do it"
- Parents need to start conversations early to practice before these become real issues and then follow up… this is not something you do once and are done with
- Parents should be informed about resources and how to respond

School Support

- ✪ Create a well-rounded health and wellness curriculum for students that include, real-life youth stories, personal experiences and use compelling, fact-based information to inform students about physical and mental effects of decision they make.
- ✪ Diversify the Physical Education courses for all grades to include classes such as yoga, dance, kickboxing, etc; to promote health active life style for teams.
- ✪ Emphasize and provide more nutritious and affordable food options on campus and eliminate unhealthy options.
- ✪ Educate teachers to be become more aware of the stress on students in balancing school workload and extra-curricular activities.
- ✪ Support students in exploring and planning for college and/or life goals after high school.
- ✪ Provide real life simulations of tragic events to all students to make teens think about drinking, driving, personal safety, the responsibility of making mature decisions and the impact their decisions have on family, friends, and many others.

Guiding Principals

- Schools are a good source of health information through health classes and school-wide events
- Schools should be informed about health resources and how to assist their students
- Schools should help advertise and promote community resources

Community Support

- ✪ Create more low-cost teen-oriented activities that are well advertised such as, extending City league sports teams to high school level, exercise classes and social functions.
- ✪ Increase the availability of and access to of low-cost health and wellness resources.
- ✪ Improve enforcement and monitoring of current laws like Driving under the influence and underage drinking
- ✪ Develop regional coordination and sharing of best practices to ensure access and utilization so Tri-Valley youth are served in all three cities.

Guiding Principals

- Make community resources more accessible via public transportation
- There need to be more fun activities that are low-cost or free—these could include sports activities, dances, pool rooms, chill spaces with couches, reading rooms or scream rooms.
- There should be separate activities or activity time slots for middle school and high school students—most will attract only one age group and the other will not feel as comfortable to attend.
- Diverse youth should be involved in planning fun/interesting educational activities

Detailed Youth Recommendations around Substance Abuse

Peer Support	• Provide peer education about need to designate drivers and look out for friends • Involve students in finding innovative new ways to educate their peers about substance use, including games, video games, etc.
Parent Support	• Educate parents to recognize symptoms and talk knowledgeably about the consequences of alcohol and drug abuse • Educate parents to provide rides home to their children whenever needed and save questions, lectures or anger until later
School Support	• Health education should stress making good decisions; don't say "don't do it" • Health education should coordinate with student health educators to provide real, compelling and facts-based information about consequences – don't be afraid to use scare tactics like real life speakers who have been through the issue or morgue pictures/visits • Schools should offer more substance-free activities – more dances, movie nights, etc. • Schools should loosen-up at dances (i.e. let students choose the music) – when events are less fun, people leave early to go to parties with alcohol and drugs • Comprehensive and continuation schools should implement "Every 15 minutes" all-day mock activity with all grade-levels (esp. sophomores, juniors and seniors) • Schools should find more funding for challenge day in high schools and violence prevention programs for younger kids
Community Support	• Community should explore ways to implement a guaranteed ride home program for stranded teens (i.e. a free service for students stranded unexpectedly due to drinking or drug use) • Community should provide more small classes that work like Axis support groups, except free • Law enforcement should provide stricter enforcement and punishments for DUI (more patrols, longer jail time and higher fines)

Detailed Youth Recommendations around Reproductive Health

Peer Support	• Friends talking to friends about consequences of sex, particularly unprotected sex • Peer pressure to be safe and avoid "dangers" • Teen run health classes that educate about sexually transmitted infections (STIs), as well as pregnancy as a major issue… begin comprehensive sex education in 7th grade and provide ongoing refresher courses through senior year • Teen-to-teen hotline, webpage, email • *Reproductive Health.* Buddy system of pairing upper classmen with Freshman/Sophomores to train them about relationship dynamics and making educated decisions.
Parent Support	• Messages should reiterate that any teen that has sex is at risk for pregnancy and STDs… teach abstinence as the best method, but advocate protection as the next best choice • Education that many teens in Tri-Valley are at a stage where they are beginning to think critically about dating, relationships and sexual activity… a number of teens, particularly older teens are already sexually active • Parents should try to tamper down their anger with their child if they find birth control or condoms… It doesn't necessarily mean that their child is having sex, it means that they are being responsible with their planning or choice to have sex • Parents should have training on how to best deal with and support a child that gets pregnant or is diagnosed with an STI
School Support	• Messages should reiterate that any teen that has sex is at risk for pregnancy and STDs… teach abstinence as the best method, but advocate protection as the next best choice • Don't teach abstinence only; teach consequences, making good decisions • A class/advisor to teach about using condoms and birth control
Community Support	• Easier ways to get protection • More places to go for pregnancy – prevention, testing, options, support • Promote STI testing • Better advertising and promotion of current resources

Detailed Youth Recommendations around Mental Health

Peer Support	• Peer advocacy counseling programs in which peers train/approach peers… these should recruit different (non-stereotypical) leaders • Peer educators to inform peers about teen rights and minor consent • Create a High School buddy/peer support system that helps freshman and new students to adjust to school.
Parent Support	• Educate parents to identify symptoms of depression/suicide, how to react, and how to be non-judgmental, provide safe haven and help • Parents should be trained on how to talk to teens without increasing their child's stress
School Support	• Teachers should be educated about how to recognize symptoms of mental health issues like stress, depression and suicide prevention and how to be non-judgmental when giving help • Teachers and schools should be more compassionate about homework load and how it relates to lack of sleep and student stress due to college applications and school events • Schools should strive for a youth-friendly, relaxing atmosphere (i.e. good colors, soothing music) • Schools should have more youth friendly counselors to help with teen issues like stress, depression, suicide prevention and follow-up. Should be proactive, non just crisis-management • Schools should require students to see a counselor every year • Schools should collaborate with community organizations to provide more career/future planning counselors or courses (i.e. college applications, job training, money management) • More adult supervision on campus before school, passing periods, after school and behind school
Community Support	• More activities for youth to interact with other youths, i.e. summer camps • Stress reduction activities • Places to de-stress, like a punching bag, boxing class or screaming room • Volunteering activities to connect with younger youth • Chill space or community center with fun and free activities • Socially active buddies - look for common interest, for students that want or appear to need help • Need for confidential spaces that are truly safe • Collaborate with schools to provide more youth-friendly counselors for teen issues like stress, depression, suicide prevention and follow-up. Should be proactive, non just crisis-management • More conflict management programs

Detailed Youth Recommendations around Physical Health

Peer Support	No specific suggestions from focus groups
Parent Support	No specific suggestions from focus groups
School Support	• Schools should provide alternative sports for P.E. classes (i.e. kickboxing or yoga) • Schools should coordinate with other community programs to provide and market additional sports activities in the community • Schools should provide healthy foods at a reasonable price • Classes should start one hour later to allow students more time for sleep • Schools should consider logistics of having mandatory study-hall one day a week • Schools should work with students to explore possibility of cutting-down on homework and having more work time available in class
Community Support	• Extend children's sports leagues (like CYO/PYB) through high school • Non-competitive sports after school • Teams or sports programs for alternative sports like skateboarding or yoga • Youth created exercise groups, like a walking, running or basketball group (free/low-cost – use public facilities) • Exercise spaces just for teens • Discounted rate at a small gym (like Express in Pleasanton) • More dances or an under 18 dance club for teens – should play lots of different types of music including hip-hop, reggaeton, salsa and rap

Attachment 1:
Copy of Survey Instruments

Tri-Valley Adolescent Health Initiative Student Survey
_____ High School, Spring 2006

1) Grade level: ☐ 9th ☐ 10th ☐ 11th ☐ 12th

2) Gender: ☐ Male ☐ Female

3) How do you describe yourself? (Check all that apply)

☐ White	☐ East Asian	☐ Middle Eastern
☐ Latino	☐ Pacific Islander	☐ Other:_____
☐ African American	☐ South Asian	☐ Prefer not to reply

4) How important do you feel the following health topics are among students at your school? (Check one answer for each topic)

	Not so Important	Somewhat important	Very important
a. Stress and depression	☐	☐	☐
b. Alcohol and drug use	☐	☐	☐
c. Peer Pressure	☐	☐	☐
d. Driving under the influence	☐	☐	☐
e. Nutrition and exercise	☐	☐	☐
f. Birth control and STDs	☐	☐	☐

Are there any other health topics that you feel are important to students at your school?

_____

5) What resources do you think are needed at your school or in your community that you would like to see more of? (Check all that apply)

- ☐ Medical services
- ☐ Transportation
- ☐ Drug education
- ☐ Sex education (including safe sex, birth control and STDs)
- ☐ Counselors to help with mental and physical health issues
- ☐ Counselors to help with college or career decisions
- ☐ Options or classes for people who aren't interested in going to college
- ☐ Help with practical stuff like cooking healthy foods or keeping a checking account
- ☐ Low cost exercise classes (yoga, martial arts, basketball, etc.)
- ☐ Conflict resolution programs
- ☐ Other: _____

6) How often does not having transportation keep you from doing things you need or want to do? (Check one)

☐ Never ☐ Sometimes ☐ Usually ☐ Always

7) What is the furthest that you would feel comfortable traveling to access confidential health and wellness services (i.e. reproductive health care or mental health services)?

Walking (Check one)	Bus (Check one)	Driving (Check one)
☐ 10 minute walk	☐ 10 minute bus ride	☐ 10 minute drive
☐ 20 minute walk	☐ 20 minute bus ride	☐ 20 minute drive
☐ 30 minute walk	☐ 30 minute bus ride	☐ I wouldn't drive
☐ I wouldn't walk	☐ I wouldn't ride the bus	

8) During the past year, how often did you get care when you needed it for?
(Check one answer for each type of care)

	Always	Sometimes	Never	I didn't need care	Don't know
a. Medical care when you were sick or hurt	☐	☐	☐	☐	☐
b. Help with confidential issues like birth control/condoms or STDs	☐	☐	☐	☐	☐
c. Counseling to help you deal with issues like stress, depression or family problems	☐	☐	☐	☐	☐

9) And, where did you usually get the following types of care:
(Check one answer for each type of care)

	Kaiser	Axis	Valley Care	School Nurse or Counselor	Other	I didn't need care	Don't know
a. Medical care when you were sick or hurt	☐	☐	☐	☐	☐	☐	☐
b. Help with confidential issues like birth control/condoms or STDs	☐	☐	☐	☐	☐	☐	☐
c. Counseling to help you deal with issues like stress, depression or family problems	☐	☐	☐	☐	☐	☐	☐

10) Who would you talk to about major health issues/ concerns? (Check all that apply)

☐ Friends	☐ Coaches
☐ Siblings	☐ Parents/Guardians
☐ Teachers	☐ Doctors
☐ Counselors	☐ Other: _____

11) Are you living up to your expectations of yourself? (Check one)

☐ Yes ☐ No

12) Of the following, what are the **3** biggest causes of stress in your life? (Check only **THREE**)

☐ Academics
☐ Sports
☐ Family
☐ Friends
☐ Other: _____
☐ Extracurricular activities
☐ Lack of time
☐ Job
☐ Future (college, plans after high school…)

13) Do you feel that the majority of students at your school generally accept you for who you are? (Check one)

☐ Yes ☐ No

14) How do you see yourself physically and mentally? (Check all that apply)

☐ In-shape
☐ Slender
☐ Overweight
☐ Attractive
☐ Unattractive
☐ Determined
☐ Confident
☐ Unmotivated
☐ Intelligent
☐ Unintelligent
☐ Average
☐ Geeky
☐ Too short
☐ Too tall
☐ Other:_____

15) Have you ever felt you were discriminated against at school based on your: (Check all that apply)

☐ Race/ethnicity
☐ Appearance
☐ Social group
☐ Sexual orientation
☐ Gender
☐ Other:_____
☐ Intelligence

16) If healthy foods were available at your school for a reasonable price, would you buy them? (Check one)

☐ Yes ☐ No

17) On average how many home cooked dinners do you have every week? (Not TV Dinners) _____

18) On average, how much exercise do you get outside of school per week? (Check one)

☐ 0 hours
☐ 1-3 hours
☐ 4-6 hours
☐ 7-9 hours
☐ 10+ hours

19) What are the top **4** drugs that you know **FOR A FACT** are being used by students at your school? (Check only **FOUR**)

☐ Tobacco
☐ Marijuana
☐ Shrooms
☐ Ecstasy
☐ LSD (Acid)
☐ Crystal-Meth
☐ Speed
☐ Cocaine
☐ Other:_____

20) What are the top **3** reasons teens use drugs and/or alcohol? (Check only **THREE**)

- ☐ Stress
- ☐ Pressure
- ☐ Boredom
- ☐ To Escape Reality
- ☐ To Fit In
- ☐ Enjoy Feeling It Gives Them
- ☐ Other:_____

21) Have you ever driven under the influence of drugs and/or alcohol? (Check one)

- ☐ Yes
- ☐ No
- ☐ Does not apply

22) Have you ever been in a car in which the driver was under the influence of drugs and/or alcohol? (Check one)

- ☐ Yes
- ☐ No

23) When you go out with your friends, and plan on being under the influence, how often do you secure a sober driver? (Please check one)

- ☐ Always
- ☐ Usually
- ☐ Rarely
- ☐ Never
- ☐ Does not apply

24) Among sexually active students at your school what do you think are the top barriers to teens using condoms and other forms of birth control? (Check all that apply)

- ☐ Money
- ☐ Embarrassment
- ☐ Don't Know How To Use It
- ☐ Think It Won't Feel As Good With It
- ☐ Pressure Not To Use
- ☐ I Don't Know
- ☐ Other:_____

25) When do you think is the right time to have sex with your partner? (Check all factors that you feel are important to have in place before you have sex)

- ☐ When You Want To
- ☐ When You Have a Partner That Wants To
- ☐ When You Have a Partner That You Trust and Love
- ☐ When You Have a Partner That You Can Talk To About Protection
- ☐ When You Get Married
- ☐ When You Reach a Certain Age
- ☐ When You Have Been Dating for a Certain Amount of Time
- ☐ Other:_____

26) If I had a boyfriend/girlfriend, I'm sure I could say no to sex, even if he/she wanted to. (Check one)

- ☐ True
- ☐ False

27) Have you ever seriously thought about hurting yourself on purpose? (Check one)

- ☐ Yes
- ☐ No

28) Do you feel that you answered these questions honestly? (Check one)

- ☐ Yes
- ☐ No

Tri-Valley Adolescent Health Initiative Student Survey
_____ Middle School, Spring 2006

1) Grade level: ☐ 6th ☐ 7th ☐ 8th

2) Gender: ☐ Male ☐ Female

3) How do you describe yourself? (Check all that apply)

☐ White	☐ East Asian	☐ Middle Eastern
☐ Latino	☐ Pacific Islander	☐ Other:_____
☐ African American	☐ South Asian	☐ Prefer not to reply

4) How important do you feel the following health topics are among students at your school? (Check one answer for each topic)

	Not so Important	Somewhat important	Very important
a. Stress and depression	☐	☐	☐
b. Alcohol and drug use	☐	☐	☐
c. Peer Pressure	☐	☐	☐
d. Nutrition and exercise	☐	☐	☐
e. Body changes and puberty	☐	☐	☐
f. Birth control and STDs	☐	☐	☐

Are there any other health topics that you feel are important to students at your school?

_____

5) What health resources do you think are needed at your school or in your community that you would like to see more of? (Check all that apply)

- ☐ Medical services
- ☐ Transportation
- ☐ Drug education
- ☐ Health education (including body changes and puberty)
- ☐ Counselors to help with mental and physical health issues
- ☐ Counselors to help with college or career decisions
- ☐ Options or classes for people who aren't interested in going to college
- ☐ Help with practical stuff like cooking healthy foods or keeping a checking account
- ☐ Low cost exercise classes (yoga, martial arts, basketball, etc.)
- ☐ Conflict resolution programs
- ☐ Other: _____

6) How often does not having transportation keep you from doing things you need or want to do? (Check one)

☐ Never ☐ Sometimes ☐ Usually ☐ Always

7) What is the furthest that you would feel comfortable traveling to access confidential health and wellness services (i.e. information about puberty, peer pressure, alcohol or drugs)?

Walking (Check one)	Bus (Check one)	Ride from adult (Check one)
☐ 10 minute walk	☐ 10 minute bus ride	☐ 10 minute drive
☐ 20 minute walk	☐ 20 minute bus ride	☐ 20 minute drive
☐ 30 minute walk	☐ 30 minute bus ride	☐ 30 minute drive
☐ I wouldn't walk	☐ I wouldn't ride the bus	☐ I wouldn't get a ride

8) During the past year, how often did you get care or information when you needed it for? (Check one answer for each type of care)

	Always	Sometimes	Never	I didn't need care	Don't know
a. Medical care when you were sick or hurt	☐	☐	☐	☐	☐
b. Answers to confidential questions about body changes or puberty	☐	☐	☐	☐	☐
c. Counseling to help you deal with issues like stress, depression or family problems	☐	☐	☐	☐	☐

9) And, where did you usually get the following types of care or information: (Please check one answer for each type of care)

	Kaiser	Axis	Valley Care	School Nurse, Counselor or Teacher	Other	I didn't need care	Don't know
a. Medical care when you were sick or hurt	☐	☐	☐	☐	☐	☐	☐
b. Answers to confidential questions about body changes or puberty	☐	☐	☐	☐	☐	☐	☐
c. Counseling to help you deal with issues like stress, depression or family problems	☐	☐	☐	☐	☐	☐	☐

10) Who would you talk to about major health issues/ concerns? (Check all that apply)

☐ Friends	☐ Coaches
☐ Siblings	☐ Parents/Guardians
☐ Teachers	☐ Doctors
☐ Counselors	☐ Other: _____

11) Are you living up to your expectations of yourself? (Check one)

☐ Yes ☐ No

12) Of the following, what are the **3** biggest causes of stress in your life? (Check only **THREE**)

☐ Academics
☐ Sports
☐ Family
☐ Friends
☐ Extracurricular activities
☐ Lack of time
☐ Job
☐ Future (college, plans after high school…)
☐ Other: _____

13) Do you feel that the majority of students at your school generally accept you for who you are? (Check one)

☐ Yes ☐ No

14) How do you see yourself physically and mentally? (Check all that apply)

☐ In-shape
☐ Slender
☐ Overweight
☐ Attractive
☐ Unattractive
☐ Determined
☐ Confident
☐ Unmotivated
☐ Intelligent
☐ Unintelligent
☐ Average
☐ Geeky
☐ Too short
☐ Too tall
☐ Other:_____

15) Have you ever felt you were discriminated against at school based on your: (Check all that apply)

☐ Race/ethnicity
☐ Appearance
☐ Social group
☐ Sexual orientation
☐ Gender
☐ Other:_____
☐ Intelligence

16) If healthy foods were available at school for a reasonable price, would you buy them? (Check one)

☐ Yes ☐ No

17) On average how many home cooked dinners do you have every week? (Not TV Dinners) _____

18) On average, how much exercise do you get outside of school per week? (Check one)

☐ 0 hours
☐ 1-3 hours
☐ 4-6 hours
☐ 7-9 hours
☐ 10+ hours

19) What do you think are the top **3** reasons teens use drugs and/or alcohol? (Check only **THREE**)

☐ Stress
☐ Pressure
☐ Boredom
☐ To Escape Reality
☐ To Fit In
☐ Enjoy Feeling It Gives Them
☐ Other:_____

20) Do you feel that you answered these questions honestly? (Check one)

☐ Yes ☐ No

Attachment 2:
State and National Data

Introduction to the State and Local Data

Please note that the following statistics are not available at the local level and are presented here to give more information and context to the issues described in the health topic fact sheets.

Substance Abuse

- In 2003, alcohol was a factor in 31% of all crash deaths among 15-21 year olds in California. In 2003, there were 190 alcohol-related crash deaths among 15-21 year olds statewide.[1]
- The average alcohol-related fatality in California costs an estimated $3.8 million: $1.0 million in monetary costs and $2.8 million in quality of life lost.[2]
- In a given year, approximately 6% of youths aged 12 to 17 are classified as needing alcohol treatment. Only 7% of those needing alcohol treatment received treatment in the past year.[3]
- 40% of those who start drinking before the age of 15 meet criteria for alcohol dependence at some point in their lives. Children who drink are 7.5 times more likely to use any illicit drug, 22 times more likely to use marijuana, and 50 times more likely to use cocaine than children who never drank.[3]
- Teens that use alcohol have higher rates of academic problems than those that don't use alcohol. Among eighth-graders, higher rates of alcohol use in the past month is associated with higher rates of truancy.[3]
- Drug use can lead to an increase in risky behaviors like needle sharing and unsafe sex. The combination greatly increases the likelihood of acquiring HIV-AIDS, hepatitis and many other infectious diseases.[4]
- Cardiovascular disease, stroke, cancer, HIV/AIDS, hepatitis, and lung disease can all be affected by drug abuse. Chronic use of some drugs can cause long-lasting changes in the brain, which may lead to paranoia, depression, aggression, and hallucinations. [4]
- 90% of adults being treated for tobacco-related illnesses start smoking as teens. The majority of daily adult smokers (82%) began smoking before 18 years of age, and more than 3,000 adolescents begin smoking each day.[5]
- Cigarette smoking and exposure to second-hand-smoke among peers are important contributors to asthma attacks among teens. These also contribute to other chronic diseases such as heart disease, cancer and stroke that will affect teens later in life.[5]
- Tobacco use is the leading cause of preventable death in the United States.[5]

Reproductive Health

- Alcohol use by teens is a strong predictor of both sexual activity and unprotected sex.[6]
- A survey of high school students found that 18% of females and 39% of males say it is acceptable for a boy to force sex if the girl is high or drunk.[6]
- The teen birth rate has declined slowly but steadily from 1991 to 2004 with an overall decline of 33% for those aged fifteen to nineteen.[7]
- National data indicate that one-third (34%) of young women have become pregnant at least once before they have reached the age of twenty. Eight-in-ten of these pregnancies are unintended.[7]
- Poor and low-income teens — who make up approximately 40% of the adolescent population — account for 83% of teens who give birth and 85% of those who become an unmarried parent.[8]
- 70% of teen mothers drop out of high school, making pregnancy a key reason young women drop out early. Only 30% of teen mothers complete high school by age thirty, compared to 76% of women who delay parenthood until age twenty-one or older. Teen mothers are also less likely to attend college than women who delay childbearing.[9]

- In addition, teen mothers are more likely to end up on welfare. The annual earnings of teen fathers have been found to be 10-15% less than for men who do not have children during their teen years.[9]

Mental Health

- Nationally, one-in-five children and teens suffer from mental health problems and the number is growing. Less than half of those suffering from mental health problems receive treatment.[10]
- Mental health disorders can interfere with the way that adolescents think, feel, and act. When untreated, these disorders can lead to school failure, family conflicts, drug abuse, violence, and even suicide.[10]
- In 2003, 9% of students in public and private high schools had attempted suicide in the past year.[10]
- The rate of suicide among those 10-14 years of age is reported as having increased by 100% from 1980-1996, with a 14% increase among those 15-19.[11]
- Many students who are the victim or witness of harassment and bullying suffer from mental health issues like depression and anxiety.[12]

Physical Health

- According to the California Health Interview Survey, long waits before doctor appointments, lack of health insurance and parents seeing no need for services were key reasons that teens did not get the medical care they felt they needed.[13]
- In many situations, delay or lack of health care for sickness, injury, or mental health can increase the severity of physical symptoms and increase the risk of hospitalization or even death.[14]
- Overweight adolescents have a 70% chance of becoming overweight or obese adults.[15]
- The prevalence of overweight among adolescents 12-19 years of age more than tripled between 1976-1980 and 1999-2002.[16]
- In California, African-American and Latino youth face higher rates of overweight and poor fitness than White and Asian youth.[17]
- Fitness experts recommend that teens get at least an hour of moderate to vigorous exercise each day.[18]
- Poor diet and physical inactivity is the second leading cause of death and disability, resulting in nearly 30,000 deaths each year among all age groups in California.[19]

State and National Data Sources

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[3] US Department of Health and Human Services National Institute on Alcohol Abuse and Alcoholism (http://www.niaaa.nih.gov/)

[4] US Department of Health and Human Services National Institute on Drug Abuse (http://www.nida.nih.gov/)

[5] Centers for Disease Control and Prevention (CDC) Tobacco Information and Prevention Source (TIPS) (http://www.cdc.gov/tobacco/index.htm)

[6] US Department of Health and Human Services and SAMHSA's National Clearinghouse for Alcohol and Drug Information (http://ncadi.samhsa.gov/)

[7] National Campaign to Prevent Teen Pregnancy. (1997). *Whatever Happened to Childhood? The Problem of Teen Pregnancy in the United States*. Washington, DC.

[8] The Body, The Complete HIV/AIDS Resource is a service of Body Health Resources Corporation (www.thebody.com)

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[10] US Department of Health and Human Services Substance Abuse and Mental Health Services Administration (www.samhsa.gov)

[11] UCLA Mental Health Project (http://smhp.psych.ucla.edu/)

[12] US Department of Health and Human Services Substance Abuse and Mental Health Services Administration (http://www.family.samhsa.gov/teach/bullies.aspx)

[13] California Health Interview Survey AskCHIS Data Query System, copyright 2003 by the Regents of the University of California, all rights reserved (http://www.chis.ucla.edu)

[14] Comparable health indicators — Canada, provinces and territories, 12-PC: Hospitalization rate for ambulatory care sensitive conditions. Published by authority of the Minister responsible for Statistics Canada © Minister of Industry, 2004, all rights reserved. Catalogue no. 82-401-XIE. Frequency: Biennial. ISSN 1703-9363. Ottawa. (http://www.statcan.ca/english/freepub/82-401-XIE/2002000/considerations/pc/12pc.htm)

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[17] *Epidemic: Overweight and Unfit Children in California Assembly Districts,* produced by the California Center for Public Health Advocacy, 2003

[18] Dietary Guidelines for Americans 2005

[19] California Department of Health Services, California Obesity Prevention Initiative (http://www.dhs.ca.gov/cdic/copi/html/problem.htm)

Fremont Adolescent Health Initiative
Review of the Existing Data

– Last Updated 09/2007 -

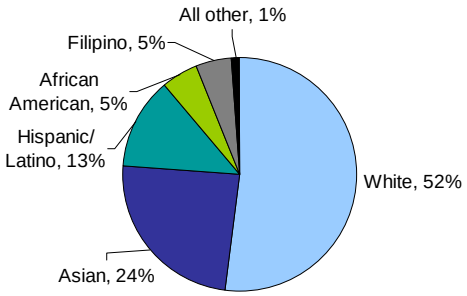
Introduction

A similar review of the existing data was first conducted in Fall 2005. The statistics were then updated in Fall 2007. This review draws upon the existing data collected by larger initiatives not directly related to the FASHI project. The majority of the local data in this review is drawn from two key sources: The California Healthy Kids Survey (CHKS) and the City of Fremont Youth Needs Assessment. More detailed information about data sources is available at the end of this summary.

Increasing diversity among students

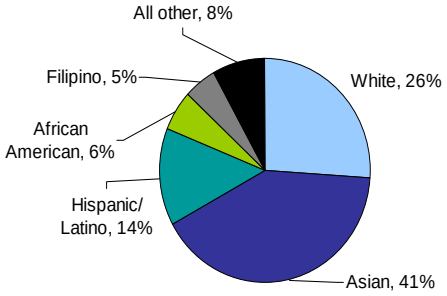
The K–12 student population in Fremont is becoming increasingly diverse. Between the 1995–1996 and 2005–2006 school years, we see a substantial decrease in the number of White students (–7,102) and a substantial increase in the number of Asian students (+6,242). This has implications on student norms, student needs, and the way we tailor our services.

Fremont Students (K–12) by race: **1995–1996**



(n=29,587)

Fremont Students (K–12) by race: **2005–2006**



(n=32,121)

Barriers to success

Through our review of the existing data, we have identified a number of key barriers that may prevent Fremont youth, from any race/ethnic group or school, from reaching their full potential:

- Tobacco, alcohol, and drug use
- Motor vehicle crashes
- Violence
- Gang involvement
- Mental health issues
- Overweight
- Risky sexual behavior
- Lack of social activities
- Obstacles to accessing services

According to the data in this report, youth in Fremont tend to fare slightly better than youth countywide on such issues as alcohol and drug use, drinking and driving, and fighting, and they fare slightly worse than youth countywide on such issues as harassment at school and being overweight.

Findings by health topic area

Tobacco use

- According to the CHKS student surveys, the rate of cigarette smoking in the past month was slightly lower among 11th graders in Fremont (9%) than Countywide (12%).
- **This is important because:**
  - Adolescence is a key time for tobacco prevention and smoking-cessation programs.
  - Cigarette smoking and exposure to second-hand smoke among peers are important contributors to asthma attacks among teens. They also contribute to other chronic diseases such as heart disease, cancer, and stroke that will affect teens later in life. These chronic diseases are common causes of disability and premature death among middle-aged adults and seniors.

Alcohol use

- According to the CHKS student surveys, the proportion of students that binge-drank in the past month was slightly lower among 11th graders in Fremont (14%) than Countywide (18%). Binge-drinking is defined as having five or more alcoholic drinks within a couple of hours.
- One in four Fremont 11th graders (26%) reported that they drank alcohol in the past month, compared to 32% of County 11th graders.
- **This is important because:**
  - Excessive alcohol use, such as binge-drinking, can have many short- and long-term effects.
  - In the short term, excessive drinking increases risk for serious car accidents such as motor vehicle crashes, unprotected sex, and rape.
  - In the long term, alcohol use can lead to liver damage (cirrhosis), certain types of cancer, and high blood pressure, and can hinder success at home, school, and work.

Other drug use

- The City of Fremont Youth Needs Assessment found that 19% of high school students and 24% of parents in Fremont feel that more drug-education services are needed in the schools.
- According to the CHKS student surveys, the proportion of students that smoked marijuana in the past month was slightly lower among 11th graders in Fremont (12%) than Countywide (17%).
- A much smaller proportion of 11th graders in Fremont (<5%) reported using other drugs, such as cocaine, methamphetamines, or psychedelics, in the past month.
- **This is important because:**
  - Marijuana use can lead to loss of coordination and to learning and memory problems.
  - Other drugs such as ecstasy and cocaine can cause other, more serious problems, such as cardiovascular collapse, seizures, kidney failure, and long-term brain damage.

Motor vehicle crashes

- Motor vehicle crashes are the leading cause of death among Fremont youth.
- From 2000–2003, motor vehicle crashes accounted for nearly one third (29%) of the 35 deaths among Fremont youth age 15–24 years.
- The proportion of 11th graders that had ever driven after drinking or driven with a friend after that friend had been drinking was lower in Fremont (20%) than Countywide (25%).
- **This is important because:**
  - In many cases, motor vehicle crashes can be prevented.
  - Alcohol and drug use increase an adolescent's risk of being injured in serious car accidents, drowning, drug overdoses, and falls.

School and community violence

- The City of Fremont Youth Needs Assessment found that 19% of high school students and 28% of parents say that more conflict-resolution programs are needed in the schools.
- According to the CHKS student surveys, the proportion of 11th graders that reported having been in a fight at school in the past year was slightly lower in Fremont (14%) than Countywide (16%).
- More than one third of 11th graders in Fremont (36%) and Countywide (33%) reported having been harassed on school property in the past year.
- The City of Fremont Youth Needs Assessment found that 18% of Fremont high school students had been worried about being jumped by a gang.
- **This is important because:**
  - Violence and aggression are preventable.
  - Many students who are victims or witnesses of violence, harassment, or bullying suffer from mental health issues such as depression and anxiety.

Dating violence and rape

- According to the CHKS student surveys, the proportion of 11th graders that have ever been hit, slapped, or physically hurt on purpose by a boyfriend or girlfriend was similar in Fremont (4%) and Countywide (6%).
- National statistics indicate that one in ten high school students (9%) has been forced to have sexual intercourse when they didn't want to.
- **This is important because:**
  - Research indicates that victims of dating violence and rape are more likely to consider and attempt suicide and more likely to experience other mental health issues such as low self-esteem, low levels of emotional well being, and eating disorders.
  - Most rape victims are young women, and most have known the perpetrator prior to the rape.

Gang involvement

- According to the CHKS student surveys, the proportion of 11th graders who have ever belonged to a gang was slightly lower in Fremont (5%) than Countywide (7%).
- **This is important because:**
  - Youth in gangs may be more likely to be involved in violent or drug-related activities and arrested.

Lack of social connections and support

- The City of Fremont Youth Needs Assessment found that 9% of Fremont high school students had negative feelings and got little structure or support from their families.
- Ten percent of Fremont high school students reported that they didn't have an adult, other than their parent or guardian, who they could go to for help, and 14% reported that they didn't have a teacher that gave them the support they need to do well in school.
- A much smaller proportion of Fremont high school students (<3%) reported not having close friends they can hang out with or talk to about things that are bothering them.
- **This is important because:**
    - Social connections and support have shown to be fundamental for positive youth development, wellness, and success.

Depression and suicide ideation

- According to the City of Fremont Youth Needs Assessment, 19% of high school students identified mental health services for depression as an important community need.
- According to the CHKS student surveys, the proportion of 11th graders that experienced substantial depression in the past year was similar in Fremont (31%) and Countywide (31%). Substantial depression is defined as depression that made someone feel so sad and hopeless almost every day for at least two weeks that they stopped doing some of their usual activities.
- According to the City of Fremont Youth Needs Assessment, approximately 20% of Fremont high school students reported having felt suicidal in the past year.
- **This is important because:**
    - Help is available, and most youth in need of mental health services do not get them.
    - There are often long delays between the onset of mental health symptoms and treatment.
    - Left untreated, mental disorders can become more severe and more difficult to treat, and co-occurring mental illnesses can develop.

Overweight

- According to the CHKS student surveys, the proportion of 11th graders that were overweight or at risk for becoming overweight was higher in Fremont (37%) than Countywide (26%).
- **This is important because:**
    - The major causes of overweight, namely unhealthy diet and lack of exercise, can be modified for better health. Adolescence is a good time to instill healthy habits.
    - The proportion of adolescents that are overweight has been steadily increasing over the past twenty years. This trend is expected to continue.
    - Overweight adolescents have a high risk of becoming overweight adults.
    - People who are overweight or obese are more likely to be depressed and to have chronic diseases such as arthritis, diabetes, certain types of cancer, heart disease, and stroke.

Risky sexual behavior

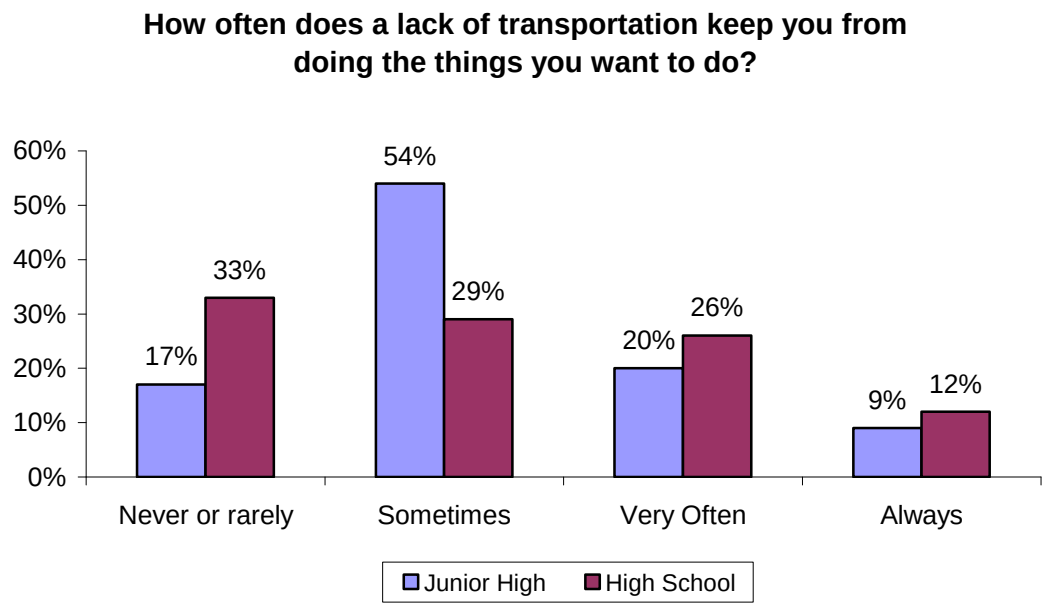
- The City of Fremont Youth Needs Assessment found that 23% of high school students and parents in Fremont felt that more sex-education services were needed in the schools; 17% of high school students and 21% of parents felt that teen-parenting programs were needed in the schools.
- There is currently no good local data about the proportion of Fremont or Alameda County adolescents who are sexually active or who have had sex without condoms.
- Statewide, one-quarter of adolescents (26%) have been sexually active and, of these, nearly half (45%) did not use a condom the last time they had sex.
- **This is important because:**
    - Adolescents can be exposed to sexually transmitted infections such as Chlamydia, Gonorrhea, and HIV/AIDS. In addition, adolescents who do not use any form of birth control are also at risk for pregnancy and becoming teenage parents.

Lack of social activities

- The City of Fremont Youth Needs Assessment found that 42% of high school students wanted a teen center, and 75% of parents expressed ‘some’ or ‘a lot of’ need for after-school programs.
- In terms of recreational activities, high school students wanted activities like social dances, an open gym, dance classes, and places to listen to music, and junior high students wanted activities like field trips, social dances, aquatics, basketball, dance classes, and TV/video classes.
- **This is important because:**
    - Recreational activities can provide healthy and constructive ways for adolescents to use their free time.

Transportation barriers

- The City of Fremont Youth Needs Assessment found that students, parents, and providers all cited transportation as an important barrier that keeps youth from accessing existing services and programs in Fremont.
- Fremont is a large city that covers 92 square miles of land (over 10% of the land in Alameda County). Many adolescents live in neighborhoods and attend schools that are located far from comprehensive medical, mental health, and recreational services and require a ride from a friend or parent.
- Adding to these issues, 45% of high school students reported that they felt unsafe on buses in Fremont.



- **This is important because:**
  - Transportation barriers can limit a young person's ability to travel to health services.
  - Such barriers can especially impact access to confidential mental health and family planning services if the adolescent needs to ask a parent, other adult, or friend for a ride.

Lack of existing health and wellness services for teens

- When the City of Fremont Youth Needs Assessment asked what youth services are missing or deficient in Fremont, 20% of high school students said a Teen Health Clinic, 19% said a Depression Clinic, 15% said a Teen Crisis Hotline, and 14% said Peer Counseling. These ranked after employment services, a teen center, college services, and extended library hours.
- **This is important because:**
  - The Fremont Adolescent Health Initiative has funding to support enhanced or additional health and wellness resources for youth in Fremont.

Lack of health insurance

- Countywide, one in twenty adolescents age 12–17 years (6%) do not have health insurance. Even among those with basic health insurance, many programs do not cover specialized services such as mental health, vision, or dental care. Though we do not have health insurance data specific to youth in Fremont, we expect that this issue is a barrier for a subset of local youth.
- **This is important because:**
  - Individuals without health coverage are less likely to access preventive services.
  - Preventive services can encourage youth to adopt more healthy eating habits, seek treatment for mental health issues, and reduce their use of alcohol and other drugs.

Sources

Detailed information about two key data sources

The 2005 CHKS collected information from 72% of Fremont 11th graders (n=669) on a variety of health and wellness indicators. In previous years, separate CHKS data was available for students from Robertson Continuation. Due to a low response rate in 2005 (<10%), we are not able to split out data for Robertson, and students from Robertson are not included in the 11th grade estimates, which only include comprehensive high schools. Data from previous years suggests that students at Robertson have much higher rates of binge-drinking, drunk-driving, fighting, weapons possession, and overweight.

The City of Fremont Youth Needs Assessment project also conducted student surveys in 2000 with students during the regular school year and during the summer school classes. The City of Fremont Youth Needs Assessment found a higher level of overall need among students in summer school.

Sources by health topic area

Demographics:

California Department of Education Standards and Assessments Division; available online at http://www.ed-data.k12.ca.us/welcome.asp.

Substance use:

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2001 California Health Interview Survey's AskCHIS data query system, copyright © 2003 by the Regents of the University of California, all rights reserved; available online at http://www.chis.ucla.edu/.

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2001 California Health Interview Survey's AskCHIS data query system, copyright © 2003 by the Regents of the University of California, all rights reserved; available online at http://www.chis.ucla.edu/.

Lack of social activities:

2000 City of Fremont Youth Needs Assessment Report.

Obstacles to accessing services:

2000 City of Fremont Youth Needs Assessment Report.

2001 California Health Interview Survey's AskCHIS data query system, copyright © 2003 by the Regents of the University of California, all rights reserved; available online at http://www.chis.ucla.edu/.

Highlights From the Fremont Adolescent School Health Initiative Needs Assessment

– Last updated 09/2007 –

OVERVIEW

This Needs Assessment was spearheaded by the Fremont Adolescent School Health Initiative (FASHI), a collaboration between the Alameda County Health Care Services Agency, the Fremont Unified School District, the City of Fremont, and County Supervisor Scott Haggerty. The FASHI Needs Assessment took place between December 2005 and June 2007.

In December 2005, the Needs Assessment kicked off with a review of the existing data and a youth engagement series to collect more information about the predominant health issues affecting youth in Fremont and the schools that are most impacted by these factors. These activities helped FASHI identify access to care and behavioral health as key issues affecting Fremont youth and identified Kennedy High, Robertson Continuation, and Walters Junior High as target schools for start-up efforts.

During the following school year, FASHI conducted further quantitative and qualitative data collection at the target schools, using student and parent/guardian surveys, a force-field analysis of strengths and weaknesses, a series of student discussion groups, and a staff survey. In summer 2007, FASHI convened a second engagement series with youth from Kennedy and Robertson to identify the most important barriers and opportunities for improving health among students at their schools. This qualitative-data collection effort confirmed access to care and behavioral health as top youth-health issues in Fremont, documented student and adult stakeholder support for school-based health programs, and generated a concrete list of ideas for improving student health programs from both student and adult stakeholder perspectives.

The purpose of this document is to summarize the information collected by the FASHI Needs Assessment. An appendix of detailed findings is included under Tab 5.

For more information about the FASHI Needs Assessment, please contact the Alameda County Health Care Services Agency: Wendi Wright, Assessment Coordinator, at 510-618-3425 or wendi.wright@acgov.org, or Jamie Hintzke, Fremont Planning Consultant, at 925-876-2380 or jamie.hintzke@acgov.org.

KEY FINDINGS BY TOPIC AREA

Purpose

This section compiles information from all assessment data collected to date. This is a good source of information about the health issues facing students at the target schools as it includes regional data not available at the school-site level.

Due to the small number of surveys at each site, this section provides more robust combined estimates for the student, parent/guardian, and school staff survey data collected at the target schools. One should

still use caution in interpreting the combined survey results due to the small numbers and response rates at each site.

Topic 1: Access to Services

WHY IS THIS A TOP ISSUE?

Youth and adults identify access to services as a key issue.

- In the 2006 Summer Youth Engagement Series, access to services was identified as one of the top three issues affecting students in Fremont.
- Staff representatives from Kennedy, Robertson, and Walters identified access to mental health, substance abuse, violence prevention, and reproductive health services as key issues at these schools.

Some services are particularly difficult for teens to get.

- Results from the Student Surveys at Kennedy, Robertson, and Walters show that it can be difficult for students to get counseling and reproductive health services when they need them:
  - 20% of respondents said it would be difficult to get general medical care.
  - 39% said it would be difficult to get counseling for stress, depression, or family problems.
  - 44% said it would be difficult to get help with issues like birth control/condoms or STDs.
- In the Student Reflections at Kennedy and Robertson, participants said that it is hard for them to get help for a variety of issues, including:
  - Alcohol and drug treatment services
  - Counseling for issues like stress, relationship problems, suicide prevention, and abuse
  - Pregnancy testing, STD checks, free birth control/condoms, HPV vaccine, and rape counseling
  - Prescriptions and help with less serious medical issues, such as migraines and weight control

WHAT ARE THE BARRIERS TO ACCESSING SERVICES?

Many youth don't know about existing resources.

- In the 2006 Summer Youth Engagement Series, students noted that a top barrier to accessing services is that many Fremont students do not know about existing resources in their community.
- In the Student Reflections at Kennedy and Robertson, participants noted that students will not use existing services if they aren't aware of where to get help.

Transportation.

- In the City of Fremont Youth Needs Assessment, students, parents, and health providers all cited transportation as a key barrier that keeps youth from accessing existing services and programs.
- In the Student Survey at target schools, 36% of student respondents said that transportation usually or always keeps them from doing things they want or need to do.
- In the Student Reflections at Kennedy and Robertson, participants mentioned the distance of the Tri-City Teen Clinic as a barrier to getting medical services.

Other factors.

- Money and insurance were other factors identified in the Reflections at Robertson and Kennedy.
- In the Student Reflections, participants also noted that students will not use existing services if they don't recognize they have a problem, or are embarrassed or shy.

WHAT CAN BE DONE TO IMPROVE ACCESS TO SERVICES?

Provide more school-based services.

- In the 2006 Summer Youth Engagement Series, the students noted that there should be more school-based services to increase access to health care.
- In the Student Survey at target schools, 61% of student respondents said they would like to see more medical, health education, and counseling services at their schools.
- In the Parent/Guardian Survey at target schools, the majority of respondents (range: 63–91%) thought it was important for students to have access to health education, support groups, counseling, family planning, and medical services at or near the target school.
- In the Student Reflections at Kennedy and Robertson, students noted that both high schools need specialists on campus to provide or connect students to rehabilitation services.
- In the School Staff Survey at target schools, many staff wrote about how their school could better serve students by providing more nurses, counselors, and substance-abuse specialists on campus.

Other suggestions.

- In the Student Survey at target schools, respondents were asked what would make it easier for students to access medical and counseling services:
  - ☑ 61% of respondents said free or low-cost services.
  - ☑ 55% said convenient hours and location.
  - ☑ 49% said private/confidential services.
- In the Student Reflections, participants provided many ideas about what would make students at Kennedy or Robertson, who needed services, more likely to use them. Their ideas included:
  Clinics and services should…
  - ☑ Be free, confidential, and nearby . . . much closer than the Tri-City Teen Clinic
  - ☑ Stay open on weekends and after/during school hours
  - ☑ Offer a wide variety of services so people will not know why students are there
  - ☑ Play music and offer magazines teens enjoy so students will feel more comfortable
  - ☑ Give students tools to help them improve their own lives

  Schools should work with community programs to…
  - ☑ Host a bulletin board or resource center on campus
  - ☑ Train teachers and host guest speakers to talk about resources and where to find them
  - ☑ Have more counselors students can stop in and see without needing an advance appointment
  - ☑ Give students the option of talking to a friend or peer about their issues
  - ☑ Involve parents to help them be informed and support their children on these issues

Topic 2: Safety, Substance Abuse, and Emotional Well-Being

WHY ARE THESE TOP ISSUES?

Youth and adults have identified the following as key issues:

- In the 2006 Youth Engagement Sessions, students identified violence and mental health as two of the top three issues affecting students in Fremont.
- Staff representatives from Kennedy, Robertson, Walters, and the School District identified safety, substance abuse, mental health, and youth development as key issues at the target schools.

Students are impacted by an array of safety issues.

- The California Healthy Kids Survey (CHKS) found that 36% of Fremont 11th graders had been harassed at school and 14% had been in a fight at school in the past year.
- The CHKS also found that 5% of Fremont 11th graders had belonged to a gang and that 4% had been hit, slapped, or physically hurt on purpose by a boyfriend or girlfriend.
- The Student and Parent/Guardian Surveys at target schools found that 8% of students felt unsafe, and that 8% of parents/guardians felt their child was unsafe, at school.
- Through these same surveys, students and parents/guardians both identified gangs, the fact that students don't know how to deal with anger, and diversity/respect issues as the top causes of violence among students.

Students use and abuse alcohol and other drugs.

- The CHKS found that 14% of Fremont 11th graders binge-drank in the past month and that 20% had driven after drinking or driven with a friend after that friend had been drinking.
- The CHKS also found that 9% of Fremont 11th graders had smoked cigarettes, 12% had smoked marijuana, and less than 5% used other drugs like cocaine or methamphetamines in the past month.

Students face many issues that impact their emotional well-being.

- The CHKS found that 31% of 11th graders in Fremont had experienced substantial depression in the past year that made them feel so sad or hopeless that they stopped doing some of their usual activities.
- The City of Fremont Youth Needs Assessment found that 20% of local high school students reported having felt suicidal in the past year.
- The student reflections found that students at Kennedy and Robertson face a variety of issues, including stress, depression, substance abuse, family problems, abuse, self-harm, and suicide.

Social supports and alternative activities are not always available.

- The City of Fremont Youth Needs Assessment found that 10% of Fremont high school students didn't have an adult, other than their parent/guardian, who they could go to for help, and that 14% didn't have a teacher that gave them the support they need to do well in school.
- The same Needs Assessment found that 42% of high school students in Fremont wanted a teen center and that 75% of parents expressed some or a lot of need for after-school programs.
- Fremont high school students said they wanted more activities like dances or dance classes, an open gym, and places to listen to music. Junior high students wanted dances or dance classes, field trips, aquatics, basketball, and TV/video classes.

WHAT CAN BE DONE TO IMPROVE THESE ISSUES?

Ideas to improve safety.

- In Student Surveys at target schools, 55% of respondents said they'd like to see more anger-management programs.
- In Student Reflections at Kennedy, students perceived that it is outsiders rather than students causing violence on campus. As a result, solutions should focus on both schools and the broader community.

Ideas to decrease alcohol and other drug abuse.

- In Student Surveys at target schools, 62% of respondents said they would like to see more alcohol/drug education and 59% said they'd like to see more alcohol/drug treatment programs.
- In Student Reflections at Kennedy and Robertson, participants listed an array of ideas for improving alcohol and drug education. Their ideas included the following:
  - ☑ Use the Harm Reduction Model rather than telling youth not to use alcohol and drugs.
  - ☑ Have 'cool' people, or teen guest speakers, present who know how to talk to kids.
  - ☑ Programs should provide true information about alcohol and drugs, as participants feel that some information in current programs is false (e.g., that it feels the same to be drunk or 'high').
  - ☑ Students aren't afraid of alcohol or drugs – 'show them things to scare them.'
  - ☑ Former addicts should talk to students about their experiences, including telling them about recovery and what it took for them to get over their addiction.
  - ☑ Schools should offer programs only to those who want them.

Ideas to promote emotional well-being and alternatives to violence and substance abuse.

- In Student Surveys at target schools, 56% of respondents said they'd like to see more counselors for mental health issues.
- In Student Reflections at Kennedy and Robertson, students said they wanted to reduce stigmas that have developed around their schools – for example, by organizing an exhibition of "cool stuff" done by students and having it covered by the press.
- When students from Kennedy were asked about what could be done to decrease violence (not asked at Robertson), they said they wanted more activities as alternatives to violence – better after-school activities that go beyond sports, including art and recreational classes, and multicultural events.
- In Staff Surveys at target schools, over 40% of respondents wrote ideas about how their school could better promote the development of healthy youth and increase involvement by the community. Ideas focused on providing more fun activities and events for students and hosting more fun events for families.

Topic 3: Other Physical Health Issues

WHY IS THIS IMPORTANT?

Risk of unplanned pregnancies and STDs.

- The City of Fremont Youth Needs Assessment found that 23% of high school students and parents in Fremont felt that more sex-education services are needed in the schools. Also, 17% of students and 21% of parents expressed a need for teen-parenting programs in the schools.
- There are currently no good local data about the proportion of Fremont or Alameda County adolescents who are sexually active or have had sex without condoms. Statewide, 26% of adolescents have been sexually active, and, of these, 45% did not use a condom the last time they had sex.

Many students are overweight.

- According to the California Healthy Kids Survey, 37% of 11th graders in Fremont were overweight or at risk of becoming overweight.

WHAT CAN BE DONE TO IMPROVE THESE ISSUES?

Ideas to reduce unplanned pregnancies and STDs.

- In the Student Survey at target schools, 72% of respondents wanted to see more sex-education services in their school or community that address issues such as abstinence, safe sex, birth control, and STDs. In the same survey, 68% of high school respondents wanted free condoms provided at school (Note: This was not asked of middle school students).
- In the Student Reflections at Kennedy and Robertson, participants listed a variety of ideas for improving sex education for students. Their ideas included the following:
  - ☑ Provide more than one week of sex education in freshman health (a semester was recommended, at both schools).
  - ☑ Sex education classes should use youth presenters with real-life experience.
  - ☑ Smaller groups might make it easier to discuss complicated issues.
  - ☑ The sex education classes say ‘don’t do it,’ but there should be more details and more information on safe sex.
  - ☑ The classes should provide cry-baby dolls and interactive activities to make classes more engaging and meaningful.
  - ☑ Brochures with information on campus.
  - ☑ Start sex education in junior high because many people become sexually active at a young age.

Ideas to promote healthy eating and exercise.

- In the Student Surveys at target schools, 80% of students wanted to see more free exercise classes in their school or community and 57% wanted to see more healthy food options at their school.
- In the School Staff Survey, many respondents wrote ideas about how their school could provide students with healthier food choices and provide students with more opportunities for exercise through lunchtime or after-school intramural (i.e., less competitive) sports programs or events.

KEY FINDINGS FOR EACH TARGET SCHOOL

Purpose

This section includes school-specific findings from the FASHI Needs Assessment but does not include the wider regional-level findings or results from the summer youth engagement sessions.

Please use caution in interpreting the school-specific results from the student, parent/guardian, and school staff surveys as the number of surveys and response rates were low at each site. This means that the findings could look different if we were able to go back and survey all students at these sites. Due to these same issues, we advise extreme caution in making comparisons between sites based on this data.

Please note that the detailed *Findings from the Student Reflections*, located under Tab 5, include a wealth of additional qualitative data about ideas for improving student health at each of the target schools. This is an important reference for school-level planning efforts.

Kennedy High School

WHY IS THIS A TARGET SCHOOL?

When looking at 2005–2006 data, Kennedy shows a high level of need compared to other comprehensive high schools in Fremont Unified:

- Lowest academic performance index score (713)
- Lowest graduation rate (95%)
- Highest enrollment in program for free/reduced-price meals (28%)
- Highest suspension rate (29 per 100 students)
- Highest rate of students with three or more unexcused absences or tardies in a given year (22%)
- Highest rate of overweight (37% among 9th graders)

WHAT ARE THE ADDITIONAL NEEDS-ASSESSMENT FINDINGS?

Access to services is a major issue among Kennedy students.

- Results from the Student Survey at Kennedy show the percentage of respondents who feel it would be difficult to get the following types of care if they needed it:
  - ☑ 34% said general medical care
  - ☑ 56% said counseling for stress, depression, or family problems
  - ☑ 70% said help with such issues as birth control/condoms or STDs
- In the student reflections at Kennedy, participants noted that:
  - ☑ It's difficult to get general medical care, counseling, addiction treatment, and birth control
  - ☑ The Tri-City Teen Clinic is not well known and many students don't know where it's located
  - ☑ Students would be most likely to access needed services at their own school
- In the School Staff Survey, many staff wrote that Kennedy could better serve students by:
  - ☑ Providing more nurses, counselors, and substance-abuse specialists on campus
- The analysis of strengths and barriers at the target schools found that Kennedy:
  - ☑ Has a School Nurse on campus only one half-day per week
  - ☑ Has a strong peer education and counseling program
  - ☑ Is the only target school that does not provide on-site mental health services through the Fremont Family Resource Center

Kennedy students have a number of suggestions for addressing teen health issues.
In Student Surveys at target schools, respondents were asked about the types of programs or services that they'd like to see more of in their school or community to address a variety of student health issues. Ideas that received votes by at least 50% of the respondents at Kennedy include:

- *To improve access to care:*
  - ☑ 66% said they'd like more medical, health education, and counseling services at their school
- *To help with stress, depression, and emotional well-being:*
  - ☑ 70% said they'd like more counselors for college or career decisions
  - ☑ 57% said they'd like more counselors for stress, depression, and other mental health issues
  - ☑ 51% said they'd like more teen recreational programs like fun classes and events
- *To increase safety:*
  - ☑ 61% said they'd like more anger-management programs
  - ☑ 52% said they'd like more programs to increase respect and safety around dating issues
- *To decrease alcohol and drug abuse:*
  - ☑ 66% said they'd like more alcohol and drug education
  - ☑ 66% said they'd like more alcohol and drug treatment programs
- *To improve nutrition and level of exercise:*
  - ☑ 90% said they'd like more fun exercise classes (yoga, martial arts, basketball)
  - ☑ 54% said they'd like more low-cost healthy food options for lunch at school
- *To decrease unplanned pregnancies and STDs:*
  - ☑ 69% said they'd like more sex education (including information about abstinence, birth control, and STDs)
  - ☑ 66% said they'd like free condoms to be provided at school

Kennedy parents support having services available at or near their child's school.
In the parent/guardian survey at Kennedy, over three-fourths of respondents said they think it's important for students at Kennedy to have access to the following at or near their school:

- 88% said *support groups* for issues like anger, substance abuse, nutrition, and self-esteem
- 87% said *counseling* for issues like stress, depression, and relationships
- 87% said *health education* for topics like pregnancy, violence, substance abuse, and nutrition
- 84% said *case management* such as housing, health insurance, and food/clothing assistance
- 81% said *medical services* such as physical exams, immunizations, and vision/hearing screenings
- 78% said *family planning* such as physical exams, STD/pregnancy testing, birth control prescriptions

Robertson Continuation High School

WHY IS THIS A TARGET SCHOOL?

When looking at 2005–2006 data, Robertson shows a high level of need compared to all other secondary high schools in Fremont Unified (including Kennedy and Walters):

- Lowest academic performance index score (504)
- Lowest graduation rate (76%)
- Highest enrollment in program for free/reduced-price meals (39%)
- Highest suspension rate (39 per 100 students)
- Highest rate of students with three or more unexcused absences or tardies in a given year (100%)
- Highest rate of overweight (50%)

WHAT ARE THE ADDITIONAL NEEDS-ASSESSMENT FINDINGS?

Access to services is an important issue among Robertson students.

- Results from the Student Survey at Robertson/Opportunity show the percentage of respondents that feel it would be difficult to get the following types of care if they needed it:
  - ☑ 18% said general medical care.
  - ☑ 21% said help with issues like birth control/condoms or STDs.
  - ☑ 42% said counseling for stress, depression, or family problems.
- In the student reflections at Robertson, participants noted that:
  - ☑ It's difficult to get general medical care, counseling, addiction treatment, and birth control
  - ☑ The Tri-City Teen Clinic is too far away and difficult to find
  - ☑ Students would be most likely to access needed services at their own school
- In the School Staff Survey, many staff wrote that Robertson could better serve students by:
  - ☑ Providing more nurses, counselors, and substance-abuse specialists on campus
- The analysis of strengths and barriers at the target schools found that Robertson has:
  - ☑ A School Nurse scheduled to be on campus one day per week
  - ☑ The Washington on Wheels (WOW) Van is on-site one morning per month
  - ☑ A peer education program on-site
  - ☑ A Fremont Family Resource Center Mental Health Counselor on-site, though there is generally a waiting list to get these services

Robertson students have a number of suggestions for addressing teen health issues.

In Student Surveys at target schools, respondents were asked about the types of programs or services they'd like to see more of in their school or community to address a variety of student health issues. Ideas that received votes by at least 50% of the respondents at Robertson include the following:

- *To improve access to care:*
  - ☑ 62% said they'd like more medical, health education, and counseling services at their school
- *To help with stress, depression, and emotional well-being:*
  - ☑ 56% said they'd like more counselors for stress, depression, and other mental health issues
- *To increase safety:*
  - ☑ 56% said they'd like more anger-management programs
- *To decrease alcohol and drug abuse:*
  - ☑ 59% said they'd like more alcohol and drug education
- *To improve nutrition and level of exercise:*
  - ☑ 65% said they'd like more fun exercise classes (yoga, martial arts, basketball)
  - ☑ 62% said they'd like more low-cost healthy food options for lunch at school
  - ☑ 50% said they'd like more classes to teach you how to make low-cost and healthy foods
- *To decrease unplanned pregnancies and STDs:*
  - ☑ 72% said they'd like free condoms to be provided at school
  - ☑ 72% said they'd like more free pregnancy and STD testing
  - ☑ 65% said they'd like more sex education (including information about abstinence, birth control, and STDs)

Robertson parents support having services available at or near their child's school.
In the parent/guardian survey at Robertson, the majority of respondents said they think it's important for students at Robertson to have access to the following at or near their school:

- 95% said *health education* for topics like pregnancy, violence, substance abuse, and nutrition
- 88% said *counseling* for issues like stress, depression, and relationships
- 78% said *family planning* such as physical exams, STD/pregnancy testing, and birth control prescriptions
- 76% said *support groups* for issues involving anger, substance abuse, nutrition, and self-esteem
- 66% said *case management* such as housing, health insurance, and food/clothing assistance
- 63% said *medical services* such as physical exams, immunizations, and vision/hearing screenings

Walters Junior High School

WHY IS THIS A TARGET SCHOOL?

When looking at 2005–2006 data, Walters shows a high level of need compared to other comprehensive junior high schools in Fremont Unified:

- Lowest academic performance index score (737)
- Highest enrollment in program for free/reduced-price meals (34%)
- Highest suspension rate (21 per 100 students)
- Highest rate of students with three or more unexcused absences or tardies in a given year (31%)
- Highest rate of overweight (34% among 7th graders)

WHAT ARE THE ADDITIONAL NEEDS-ASSESSMENT FINDINGS?

Access to services is a major issue among Walters' students.

- Results from the Student Survey at Walters show the percentage of respondents that feel it would be difficult to get the following types of care if they needed it:
  - ☑ 15% said general medical care
  - ☑ 30% said help with issues like body changes or puberty
  - ☑ 35% said counseling for stress, depression, or family problems
- In the student reflections at Walters, participants noted that:
  - ☑ Students need more on-site counseling for relationships, family problems, and gang issues
  - ☑ Students' ability to get services depends on their parents – they rely on them to get care
- In the School Staff Survey, staff wrote that Walters could better serve students by:
  - ☑ Providing more nurses, counselors, and substance-abuse specialists on campus
- The analysis of strengths and barriers at the target schools found that Walters has:
  - ☑ A School Nurse scheduled to be on campus one day per week
  - ☑ A peer education program on-site
  - ☑ A Fremont Family Resource Center Mental Health Counselor on-site, though there is generally a waiting list to get these services

Walters' students have a number of suggestions for addressing teen health issues.
In Student Surveys at target schools, respondents were asked about the types of programs or services they'd like to see more of in their school or community to address a variety of student health issues. Ideas that received votes from at least 50% of the respondents at Walters include the following:

- *To help with stress, depression, and emotional well-being:*
  - ☑ 63% said they'd like more teen recreational programs, such as fun classes and events
  - ☑ 54% said they'd like more counselors for stress, depression, and other mental health issues
- *To increase safety:*
  - ☑ 50% said they'd like more conflict-resolution programs
- *To decrease alcohol and drug abuse:*
  - ☑ 58% said they'd like more alcohol and drug education
  - ☑ 58% said they'd like more alcohol and drug treatment programs
- *To improve nutrition and level of exercise:*
  - ☑ 75% said they'd like more fun exercise classes (yoga, martial arts, basketball)
  - ☑ 58% said they'd like more low-cost healthy food options for lunch at school
- *To decrease unplanned pregnancies and STDs:*
  - ☑ 92% said they'd like more sex education (including information about abstinence, birth control, and STDs)

Walters' parents support having services available at or near their child's school.
In the parent/guardian survey at target schools, over two-thirds of parents from Walters said they think it's important for students at Walters to have access to the following at or near their school:

- 93% said *health education* for such topics as pregnancy, violence, substance abuse, and nutrition
- 90% said *family planning* such as physical exams, STD/pregnancy testing, and birth control prescriptions
- 88% said *medical services* such as physical exams, immunizations, and vision/hearing screenings
- 83% said *support groups* for issues involving anger, substance abuse, nutrition, and self-esteem
- 80% said *counseling* for issues like stress, depression, and relationships
- 73% said *case management* such as housing, health insurance, and food/clothing assistance

DATA SOURCES AND METHODS

As mentioned previously, this Needs Assessment draws from existing data sources as well as from additional data collection efforts specific to this project. The following is a brief description of the data sources used in this assessment, listed in chronological order. For more information, please see the detailed findings for each of these data sources under Tab 5.

I. Compilation of Existing Data (Spring 2006)

- Existing data was compiled from a variety of sources, including:
  - ☑ California Healthy Kids Survey (2005)
  - ☑ City of Fremont Youth Needs Assessment Report (2000)
  - ☑ Vital statistics data (2000–2003)
  - ☑ School-level data from the California Department of Education (multiple years)
- There are two parts to this compilation:
  - ☑ Part One includes city and district-wide data on a variety of health topics.
  - ☑ Part Two includes the available school-level data ranked by school-level need.

II. Youth Engagement Series (Summer 2006)

- A series of four youth-engagement sessions were held to promote rich discussions about teen health issues in Fremont and how existing services could be improved.
- Eleven youth participated in the sessions. They were diverse in terms of socioeconomic background, gender, grade-level, and school. (Note: Many participants were not from target schools.)

III. Student and Parent/Guardian Surveys at the Target Schools (December 2006)

- Response rates were low for both surveys at each site:
  - ☑ Student Survey: Completed by 11% (n=34) of all students at Robertson/Opportunity, 9% (n=61) of 10^{th} and 12^{th} graders at Kennedy, 6% (n=24) of 8^{th} graders at Walters.
  - ☑ Parent Survey: Completed by parents of 13% (n=43) of all students at Robertson/Opportunity, 8% (n=52) of 10^{th} and 12^{th} graders at Kennedy, 10% (n=42) of 8^{th} graders at Walters.
- The surveys relied on self-reporting and were administered in the following ways.
  - ☑ The student survey was administered via active parental consent, meaning that a student had to turn in a signed consent form from their parent before they were eligible to take the survey.
  - ☑ The parent survey was mailed or handed out along with the consent form for the student survey.
- The surveys were designed to collect additional information about the top health issues identified through the summer 2006 youth engagement series and the compilation of the existing data.
  - ☑ A student from the summer 2006 youth engagement series, as well as staff from the Fremont Unified School District, helped to give input on the survey questions.

IV. Force Field Analysis of Strengths and Weaknesses at Target Schools (Spring 2007)

- The Force Field Analysis was based on the results of interviews with key stakeholders, including principals, counselors, school nurses, and other key staff at the three target schools, as well as staff from the school district, the Family Resource Center, and the Office of Alameda County Supervisor Scott Haggerty.

V. Student Reflections at the Target High Schools (Spring 2007)

- The Student Reflections were conducted as a way to involve more students in the planning process and to collect more detailed information to build from the results of the student survey.
- The proportion of students involved in the student reflections process was 48% (n=156) at Robertson, 6% (n=86) at Kennedy, and 4% (n=31) at Walters.

VI. Staff Surveys at the Target Schools (Spring 2007)

- Response rates varied by site: 75% (n=18) at Robertson, 28% (n=25) at Kennedy, and 56% (n=22) at Walters.
- Surveys relied on self-reporting and were administered by a staff survey-coordinator at each site. Respondents represented a broad cross-section of staff including teachers, administrators, counselors, and aides.
- The surveys were administered to collect more information about staff support for providing additional health and wellness resources in the school setting.

VII. Youth Engagement Series (Summer 2007)

- A series of 14 youth engagement sessions were held to promote rich discussions, brainstorm, and prioritize ideas to address youth health issues, develop a product to share group findings, and build a foundation of empowered youths to shape and contribute to the next steps of the FASHI planning process.
- 19 youth participated in the sessions. These youth were diverse in terms of life experiences, socioeconomic background, gender, and race/ethnicity.

VIII. Mapping of Existing Community Resources (Summer 2007)

- The Mapping of Existing Community Resources was based on interviews with local programs identified through the Force Field Analysis of Strengths and Weaknesses at Target Schools.

LIMITATIONS

As with any Needs Assessment, there are limitations to keep in mind when interpreting data. A summary of key limitations to the FASHI Needs Assessment is presented below.

Limited Timeframe for Data Collection Activities
Due to a variety of factors, including staff turnover and funding deliverables, some pieces of this Needs Assessment were rushed and not as carefully planned or executed as we would have liked. We believe that this is an umbrella under which many of the other limitations fall.

Some Existing Data Are Not Available at the School-Site Level
Much of the existing data, including the California Healthy Kids Survey Results and the City of Fremont Youth Needs Assessment Data, are available regionally but not for the target schools. These regional data provide a useful backdrop but are less helpful for planning efforts at the target school sites.

Low Response Rate to Student and Parent Guardian Surveys
One of the most significant limitations to this Needs Assessment is the low response-rate to the student and parent/guardian surveys. Due to the low response rate, we advise extreme caution in making comparisons between sites. Experts would attribute most minor differences to chance.

Student Survey Administered Via Active Parental Consent
With active parental consent, students need a signed permission form to be eligible to take a survey. As students who turn in permission forms are more likely to experience protective factors such as being responsible and having an open relationship with their parents, the results may have looked different if we were able to survey all students at the target schools.

Low Rate of Students Involved in the Student Reflections at Kennedy or Walters
The low rate of student involvement makes the results less representative of the student population at these sites. In addition, the Student Reflections at Walters yielded less information, possibly because of the different level of maturity and cognitive ability among junior high students.

Low Response Rate to Staff Survey at Kennedy
The low response rate at Kennedy makes the results less representative of the school staff at this site.

Limited Student Involvement in Driving Needs-Assessment Activities
Though summer youth-engagement series were conducted in 2006 and 2007, this Needs Assessment process has lacked, to date, an ongoing youth board to develop and conduct Needs Assessment activities. In a truly youth-driven process, youth would have conducted most of the research themselves rather than giving more general guidance, and their interpretation of the results, to adult staff.

Many Statistics Not Included in This Document
This Needs Assessment collected huge amounts of detailed information, and this document presents only the highlights. Please note that an appendix of detailed findings is included under Tab V.

Unanswered Questions
Though the FASHI Needs Assessment collected huge amounts of very important planning information, it is anticipated there will be many places in which the collected data will prompt further questions. This is a natural and inherent part of any assessment process. Groups should be encouraged to collect additional data as needed throughout the planning, implementation, and evaluation phases of this project.